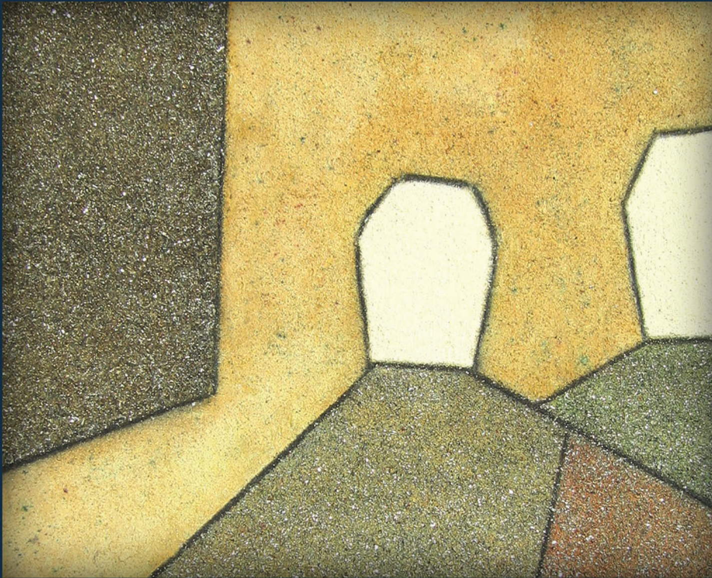
MENTALIZING in Psychotherapy

A Guide for Practitioners



Carla Sharp | Dickon Bevington

Foreword by Peter Fonagy

Guilford Press
e-book

MENTALIZING IN PSYCHOTHERAPY

Psychoanalysis and Psychological Science

Elliot Jurist, Series Editor

Books in this series aim to bridge the work of researchers and the work of clinicians. They reflect the current empirical findings and state of the art in psychoanalysis and psychodynamic treatment. They are written to be practical and relevant to clinicians.

Attachment and Psychoanalysis:
Theory, Research, and Clinical Implications
Morris N. Eagle

Minding Emotions:
Cultivating Mentalization in Psychotherapy
Elliot Jurist

The Unconscious:
Theory, Research, and Clinical Implications
Joel Weinberger and Valentina Stoycheva

Treating Pathological Narcissism
with Transference-Focused Psychotherapy
Diana Diamond, Frank E. Yeomans,
Barry L. Stern, and Otto F. Kernberg

Mentalizing in Psychotherapy:
A Guide for Practitioners
Carla Sharp and Dickon Bevington

MENTALIZING in Psychotherapy

A Guide for Practitioners

Carla Sharp
Dickon Bevington

Foreword by Peter Fonagy
Series Editor's Note by Elliot Jurist

THE GUILFORD PRESS
New York London

© 2022 The Guilford Press
A Division of Guilford Publications, Inc.
370 Seventh Avenue, Suite 1200, New York, NY 10001
www.guilford.com

All rights reserved

No part of this book may be reproduced, translated, stored in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopying, microfilming, recording, or otherwise, without written permission from the publisher.

Printed in the United States of America

This book is printed on acid-free paper.

Last digit is print number: 9 8 7 6 5 4 3 2 1

The authors have checked with sources believed to be reliable in their efforts to provide information that is complete and generally in accord with the standards of practice that are accepted at the time of publication. However, in view of the possibility of human error or changes in behavioral, mental health, or medical sciences, neither the authors, nor the editor and publisher, nor any other party who has been involved in the preparation or publication of this work warrants that the information contained herein is in every respect accurate or complete, and they are not responsible for any errors or omissions or the results obtained from the use of such information. Readers are encouraged to confirm the information contained in this book with other sources.

Library of Congress Cataloging-in-Publication Data

Names: Sharp, Carla, author. | Bevington, Dickon, author.
Title: Mentalizing in psychotherapy : a guide for practitioners / Carla Sharp, Dickon Bevington ; foreword by Peter Fonagy ; series editor's note by Elliot Jurist.
Description: New York: The Guilford Press, 2022. | Series: Psychoanalysis and psychological science | Includes bibliographical references and index.
Identifiers: LCCN 2022020627 | ISBN 9781462549962 (hardcover)
Subjects: LCSH: Mentalization Based Therapy. | Child psychotherapy. |
BISAC: PSYCHOLOGY / Psychopathology / Personality Disorders | PSYCHOLOGY / Movements / Psychoanalysis
Classification: LCC RJ504 .S5175 2022 | DDC 618.92/8914—dc23/eng/20220610
LC record available at https://lccn.loc.gov/2022020627

About the Authors

Carla Sharp, PhD, is Professor in the Clinical Psychology Doctoral Program and Associate Dean for Faculty and Research at the University of Houston, where she is also Director of the Adolescent Diagnosis Assessment Prevention and Treatment (ADAPT) Center and the Developmental Psychopathology Lab. Dr. Sharp holds adjunct positions at University College London in the United Kingdom and the University of the Free State in South Africa. Her work has significantly advanced scientific understanding of personality pathology in youth. She is a recipient of the Mid-Career Investigator Award from the North American Society for the Study of Personality Disorders and the Award for Achievement in the Field of Severe Personality Disorders from the Borderline Personality Disorder Resource Center. She is past President of the International Society for the Study of Personality Disorders and Associate Editor of the American Psychological Association journal *Personality Disorders: Theory, Research, and Treatment*. Dr. Sharp has published over 300 peer-reviewed publications, chapters, and books.

Dickon Bevington, MA, MBBS, MRCPsych, is a consultant in child and adolescent psychiatry, Cambridge and Peterborough NHS Foundation Trust, and Medical Director of the Anna Freud National Centre for Children and Families, London, United Kingdom. His

clinical work is with high-risk and highly complex young people with substance use disorders. At the Anna Freud Centre, alongside his Medical Director role, Dr. Bevington is a developer of and trainer in mentalization-based approaches, in particular co-leading the development of Adaptive Mentalization-Based Integrative Treatment (AMBIT), an award-winning approach used by teams across the world. He was listed as one of the "Top 50 Innovators in Health" by the *Health Service Journal* in 2014. Dr. Bevington has published on and teaches AMBIT internationally. His research interests include youth substance use disorders, implementation science, and pragmatic approaches to whole-systems change. He is a past Fellow of the Cambridge Collaboration for Leadership in Applied Health Research and Care.

Series Editor's Note

This series, *Psychoanalysis and Psychological Science,* was created in order to promote dialogue between researchers and practitioners. Carla Sharp and Dickon Bevington's book *Mentalizing in Psychotherapy: A Guide for Practitioners* embodies this goal in a thoroughly admirable way. Carla Sharp is an academic research psychologist (and clinician) and Dickon Bevington is a psychiatrist who works on the front lines with troubled adolescents for the National Health Service (and is the Medical Director of the Anna Freud Centre). This book is designed to be practical, and provides specific take-home messages along with boxes that summarize information and highlight clinical interactions in detail. The book is also a primer: it supposes no previous familiarity with mentalization or mentalization-based treatment. The authors explain the term *mentalization* and show how it is a transdiagnostic mechanism of change that can be applied to other modalities of treatment. Sharp and Bevington offer a comprehensive look at mentalization, both as contributing to salutogenesis and, in its absence, linked to psychopathology. They show us how to assess for mentalization, how to work on improving it, and also how it is part of supervision. This book is a remarkable achievement, both in leading the mentalization paradigm forward, as Peter Fonagy argues in his Foreword, and in conveying in clear language to the novice or anyone who is vaguely familiar with mentalization what the construct is and why it is such a compelling area of research and treatment.

Elliot Jurist, PhD

Foreword

When mentalization-based treatments started in the early 1990s, now a startling three decades ago, the primary objective of achieving improved mental health care for those who needed it was the introduction of evidence-based treatments (Roth & Fonagy, 1996; Fonagy, Target, Cottrell, Phillips, & Kurtz, 2002). There were several challenges. Some routinely administered treatments were harming patients as opposed to helping them. For example, individuals with a diagnosis of a borderline personality disorder (BPD) who presented for treatment in North America received treatment from an average of six psychotherapists who in combination could achieve only marginally effective clinical outcomes (Lieb, Zanarini, Schmahl, Linehan, & Bohus, 2004). In fact, behind these disappointing figures was a stark reality that most patients probably deteriorated as a consequence of psychosocial treatments that actually impeded their capacity to recover, and they failed to harness potentially advantageous changes in their social circumstances. Michael Stone's sobering follow-up of patients with this diagnosis reported only a 66% recovery rate achieved after 20 years (Stone, 1990). Clearly, treatment as usual, at least for some diagnostic groups, represented a suboptimal solution along the lines of the leeches, purging, and bloodletting of 17th- and 18th-century medicine. (It is perhaps not entirely coincidental that the latter two of these therapeutic approaches are symptoms of nonsuicidal self-injury [NSSI] and are frequently practiced by individuals with BPD diagnoses.)

The rapid development of evidence-based approaches for diagnostic conditions such as BPD represented a critical advance in patient care but also served to destigmatize conditions whose failure to respond to "treatment as usual" led them to become diagnoses of exclusion (National Institute for Mental Health England, 2003). Training programs were created that ensured that those administering treatments with solid evidence, based on randomized controlled trials, had the required competencies to do so effectively (Roth & Pilling, 2008; Roth, Pilling, & Turner, 2010). Over the past four decades, the culture of evidence-based practice in mental health acquired an unstoppable momentum. I feel proud that with colleagues developing the mentalization-based approach across a number of diagnostic groups, I played a small but significant part in delivering the ethical, moral, and pragmatic objectives of empirically supported interventions (Bateman & Fonagy, 2019).

So, is all well with the psychosocial treatment of mental disorders? There remain two major obstacles, and the current brilliant volume summarizing the principles and practice of mentalization-based therapy (MBT) represents an answer to both.

The evidence on which empirically supported treatments are based is grounded in categorical diagnoses of mental disorders. Randomized controlled trial designs are based on the assumption that disorder categories reflect nature cut at its joints; they assume an underlying reality of disorders neatly partitioned into nonoverlapping, mutually exclusive, and combinatorially exhaustive groups of disorders (Rutter, 2013). No clinician needs to be persuaded that current taxonomies are far from optimal in capturing the clinical and social needs of individuals assigned a particular label. Arbitrary thresholds preclude individuals from obtaining treatment that might be efficacious and would serve to prevent progression to more acute phases of the disorder. It is particularly challenging that inequity in the distribution of clinical resources is often marked along racial, ethnic, and socioeconomic characteristics, exaggerating rather than addressing preexisting marked social injustice. Many, including Sharp and colleagues (2015) and the authors of this book, have delivered groundbreaking findings that changed the focus from a system of fixed categories to a developmentally informed dimensional system based on a neuroscience perspective pioneered by the National Institute of Mental Health (NIMH) Research Domain Criteria framework (Sharp et al., 2016). The value of a transdiagnostic approach is widely recognized as it is

more likely to reflect the everyday life experiences of individuals with mental health problems, at the same time increasing the likelihood that inquiry and treatment are in line with underlying mechanisms, neurobiology, and optimally effective interventions. The mentalization-based therapy approach, brilliantly introduced by the authors of this volume, establishes MBT as a “poster child” of the transdiagnostic endeavor equally open to genetic mechanisms associated with neurodevelopmental difficulties as reflecting evidently transdiagnostic risk factors in early psychosocial environments associated with neglect in childhood and complex developmental trauma.

The second challenge, which has so far been largely insurmountable, derives from the prevalence of mental health problems across the population (Kazdin, 2019). There are simply too many individuals who experience mental health problems for any realistic population-informed health initiative to reach adequately. Some time ago, we did a now considerably outdated calculation. If all professionally trained clinical psychologists worked 9-hour days, doing nothing but offering individual or group treatments to patients based on best available evidence, taking no lunch breaks, they would be able to offer therapy to no more than 1 in 12 children and young people presenting with probable diagnosis of mental disorder. Evidently there is a substantial problem of access, often referred to as the *treatment gap*, which once again disadvantages those with the least resources and most significant handicaps.

This book represents a major and in my view massively significant step toward bridging the treatment gap. We assume that the treatment gap will not be bridged without empowering those *not* currently involved in the delivery of empirically informed mental health care to step up to the plate of addressing need and do their best to provide therapeutic interventions of demonstrated clinical value. And here is where the history of MBT provides a clue. MBT developed out of the need to offer psychotherapeutic help in a day hospital staffed by nurses, health care assistants, social workers, and occupational therapists who had no formal training in psychotherapeutic intervention (Bateman & Fonagy, 1999a, 1999b). MBT does not require a sophisticated psychological understanding on the part of the clinician about the complex determinants of different mental health problems. Mentalizing, as the book points out, is rooted in folk psychology. This is the not-to-be-underestimated understanding that all human beings use to interpret individual and social action. It is a fundamental

principle of the mentalization-based therapeutic approach that providing psychological understanding should be within the grasp of every human being and would enhance the well-being of all those who are challenged in terms of their understanding of their own or others' actions in mental state terms. Importantly, the MBT understanding of ineffective mentalizing is not one of a permanent deficit in what is a unique and highly protected human function but rather an understanding that in some individuals, genetic vulnerability combined with unsupportive early experiences, including neglect and trauma, may create a vulnerability: the loss of mentalizing in conditions of high emotion. This can lead to individual distress combined with difficulties in social interaction that in combination generate suboptimal coping strategies and frequently a diagnosis of mental disorder. Complementary to this assertion is our belief, resting on reasonable neuroscientific foundations, that a benign and informed social environment is capable of enhancing competencies in mentalizing and addressing vulnerabilities in a benignly therapeutic, collaborative, and deeply respectful manner.

And this is my hope for this excellent volume. It is undoubtedly the most clearly written and most easily accessible depiction of MBT that is available to date. It is possible that this affirmation of accessibility can be validly applied because I have made absolutely no contribution to writing this monograph. But precisely because of this, I very much hope that a very broad—the broadest possible—audience of practitioners interested in acquiring competencies that enable them to offer help to those around them who they sense need assistance will pick up and read this book. It is only by energizing and empowering (nontraditional) agents that we will be able to move the dial on the prevalence of mental disorders, which, tragically, despite immense efforts by developers of effective therapies, has moved little over the past four decades.

This book could, just could, be a game changer. I very much hope that its lively style, its compassionate language, and its genuine human interest provide the foundations on which a new generation of psychologically informed, trauma-sensitive, humane, generous, and competent practitioners will emerge. I'm deeply grateful to the authors of the book for doing something I know I could have never delivered. In all humility I'm deeply thankful for their efforts.

Peter Fonagy, OBE, FMedSci, FBA, FAcSS

REFERENCES

Bateman, A. W., & Fonagy, P. (1999a). Effectiveness of partial hospitalization in the treatment of borderline personality disorder: A randomized controlled trial. *American Journal of Psychiatry, 156*(10), 1563–1569.

Bateman, A. W., & Fonagy, P. (1999b). Psychotherapy for severe personality disorder: Article did not do justice to available research data. *BMJ*, *319*(7211), 709–709.

Bateman, A. W., & Fonagy, P. (Eds.). (2019). *Handbook of mentalizing in mental health practice*. Washington, DC: American Psychiatric Association Publishing.

Fonagy, P., Target, M. T., Cottrell D., Phillips, J., & Kurtz, Z. (2002). *What works for whom?: A critical review of treatments for children and adolescents*. New York: Guilford Press.

Kazdin, A. E. (2019). Annual research review: Expanding mental health services through novel models of intervention delivery. *Journal of Child Psychology and Psychiatry, 60*(4), 455–472.

Lieb, K., Zanarini, M. C., Schmahl, C., Linehan, M. M., & Bohus, M. (2004). Borderline personality disorder. *Lancet, 364*(9432), 453–461.

National Institute for Mental Health England. (2003). *Personality disorder: No longer a diagnosis of exclusion*. London: Department of Health.

Roth, A. D., & Fonagy, P. (1996). *What works for whom? A critical review of psychotherapy research*. New York: Guilford Press.

Roth, A. D., & Pilling, S. (2008). Using an evidence-based methodology to identify the competences required to deliver effective cognitive and behavioural therapy for depression and anxiety disorders. *Behavioural and Cognitive Psychotherapy, 36*(2), 129–147.

Roth, A. D., Pilling, S., & Turner, J. (2010). Therapist training and supervision in clinical trials: Implications for clinical practice. *Behavioural and Cognitive Psychotherapy, 38*(3), 291–302.

Rutter, M. (2013). Developmental psychopathology: A paradigm shift or just a relabeling? *Development & Psychopathology, 25*(4, Pt. 2), 1201–1213.

Sharp, C., Fowler, J. C., Salas, R., Nielsen, D., Allen, J., Oldham, J., . . . Fonagy, P. (2016). Operationalizing NIMH Research Domain Criteria (RDoC) in naturalistic clinical settings. *Bulletin of the Menninger Clinic, 80*(3), 187–212.

Sharp, C., Wright, A. G., Fowler, J. C., Frueh, B. C., Allen, J. G., Oldham, J., & Clark, L. A. (2015). The structure of personality pathology: Both general (“g”) and specific (“s”) factors? *Journal of Abnormal Psychology, 124*(2), 387–398.

Stone, M. H. (1990). *The fate of borderline patients: Successful outcome and psychiatric practice*. New York: Guilford Press.

Preface

Over the last 15 years, we have each, in our own way, been unpacking and demystifying mentalizing and its associated treatment—for ourselves and for others. As an academic clinical psychologist at the University of Houston running a clinic for personality challenges in adolescence, Carla Sharp has been engaged in mentalization-based research, clinical work, and training in children, adolescents, and adults. Dickon Bevington has been working "in the trenches" as a child psychiatrist, making mentalizing therapies accessible to treatment teams working with hard-to-reach teenagers in community-based mental health settings. Dickon has trained over 70 teams as well as hundreds of individual trainees in mentalization-based approaches to treatment. Together and separately, we have worked toward a basic, clear, and accessible understanding of mentalizing and treatments that is translatable to others.

Our intention in this book is to share what we have learned over the last 15 years with clinicians of all backgrounds and persuasions who wish to incorporate a Mentalizing Stance into their practice, including nurses, psychologists, social workers, and psychiatrists. The Mentalizing Stance has transformed our way of working with patients. It has also transformed our daily lives and the interactions between our work colleagues. The Mentalizing Stance asks for humility, intellectual curiosity, and the willingness to learn. Beneath its complex theoretical and evidential foundations and refinements, mentalizing is still at heart a *simple* idea, one that allows for the

connecting of minds in fruitful ways that are experienced by those involved as compassionate and creative. If complexity ever clouds this most basic measure, it is likely that mentalizing has slipped out the back door. Now, some of what we will write about is complex, but we have tried to hold on to the simplicity that makes mentalizing such a fecund and pragmatic frame for developing help that is helpful, and we hope readers will bear with us and hold on to the heart of what this is about. We are excited to have you join this journey.

THIS BOOK

This volume was born out of our experience teaching novice therapists and lay mental health workers about psychotherapy. We are delighted now to share what we have learned with you. Chapter 1 opens the book with an overview and a broad discussion of the rationale for mentalization-based therapy (MBT).

In Chapter 2 we introduce the concept of mentalizing. We talk about its psychoanalytic roots, and the way it is currently used in primatology, developmental psychology, social neuroscience, and clinical psychology and psychiatry. We introduce you to the four mentalizing polarities (self vs. other; implicit–automatic vs. explicit–controlled; affective vs. cognitive; and implicit vs. explicit). We also emphasize the importance of goals and values in mentalizing. By the end of Chapter 2, you should have a fairly good understanding of what we mean when we use the word *mentalizing*, and what optimal mentalizing looks like. This sets the stage nicely for Chapter 3, in which we discuss how mentalizing develops.

As you will learn, MBT is at its core developmental. Mentalizing theory not only understands the origin of psychopathology in its developmental (attachment) context, but views the capacity to mentalize itself as the culmination of several developmental steps toward mature mentalizing. Chapter 3 walks you through the development of mentalizing capacity from infancy, through childhood and adolescence, into adulthood. It highlights three prementalizing modes that precede the onset of mature, adultlike mentalizing: teleological mode, psychic equivalence, and pretend mode. This chapter also emphasizes that mentalizing capacity does not develop in a vacuum, but that the early caregiving environment (and later on, the social environment

writ large) provides a critical laboratory for the practicing of mentalizing skills throughout development. As such, mentalizing is rooted in attachment relationships inside and outside the home environment. It is through parental mentalizing (or reflective function) that the infant, child, and adolescent gain the capacity to view their mind from the outside in, and others' minds from the inside out. As children are mentalized by caregivers, they learn that there is something to be gained from getting another's perspective on their own mind, and they begin to develop epistemic trust in the environment as a source of social learning.

In Chapter 4, we build on the discussion of the normative (typical) development of mentalizing capacity, to explain how mentalizing development goes awry. Specifically, we discuss how disruption of an early caregiving environment could derail the development of mentalization. This derailment is the result of complex, bidirectional interactions between biology (genes) and environment. We use borderline personality disorder (BPD) as an example of how mentalizing development goes awry because MBT was originally developed in the context of BPD, and also because BPD appears to be a good proxy for assessing an individual's general level of personality functioning (Sharp et al., 2015). We explain how the prementalizing modes that are developmentally appropriate in preadolescents may be viewed as *nonmentalizing* modes associated with psychopathology in adulthood. We also explain how nonmentalizing engenders epistemic mistrust, thereby closing the opportunity for social learning and support from the environment, rendering those who struggle to mentalize feeling alone and misunderstood. In this chapter, we also point out that adolescence constitutes a significant period of vulnerability for the development of mentalizing failure and ensuing personality disorder, thereby demanding additional scaffolding from the social environment to ensure optimal personality development.

Chapter 5 gives the reader the tools for the assessment of mentalizing. This is a critical chapter because the success of MBT relies heavily on the capacity of the therapist to notice when there is a breakdown in mentalizing capacity. Therefore, the continuous assessment throughout sessions and treatment of the client's mentalizing capacity, as well as the therapist's own mentalizing capacity, form the cornerstone of MBT. We discuss the assessment of several aspects of mentalizing: overall mentalizing capacity, prementalizing modes,

mentalizing style, and mentalizing polarities. We discuss how the assessment of mentalizing early on in the work with a client informs the development of a client-specific mentalizing profile, and ultimately the mentalizing formulation, which integrates all aspects of the client's history and presenting problems but frames it in terms of mentalizing capacity. The collaborative and tentative nature of the mentalizing formulation is underscored as the first opportunity for the therapist to signal to the client what mentalizing is all about.

Chapter 6 introduces the basic structure of MBT. In this chapter, we also introduce the case of a fictional client we have named MJ. Throughout the three intervention chapters (Chapters 6, 7, and 8) we refer back to the case of MJ so that readers develop a coherent sense of the flow of mentalizing interventions. While structures of mentalization-based interventions vary, most tend to follow a classic Beginning, Middle, and End structure, where the Beginning focuses on assessment and formulation; the Middle constitutes the bulk of the therapeutic work; and the End concerns consolidation and preparation for ending the therapeutic relationship. In this chapter, we elaborate on the Beginning by expanding knowledge about the mentalizing formulation touched on in Chapter 5. By the end of Chapter 6, the reader will have a good understanding of the collaborative and tentative nature of the mentalizing formulation, which forms a working hypothesis that lies at the basis of the therapist's work in the Middle and End phases of the intervention. Understanding the importance of maintaining the Mentalizing Stance over the course of treatment will help the reader to guide the client through the termination of therapy in the final phase.

Chapter 7 elaborates the Middle phase of the intervention. Here, we introduce the Mentalizing Stance as the core *attitude* or *position* that the therapist takes. It is the Mentalizing Stance that drives therapeutic change. If you take one thing away from this book, we hope it would be how to embody the Mentalizing Stance. First, we contextualize the Mentalizing Stance within our sociopolitical context, taking into account power relations between clients and therapists. This is important, because it reintroduces the idea that MBT is nonauthoritative. We then outline various criteria for assessing whether a Mentalizing Stance is maintained. These include not-knowing; inquisitive, open-source thinking; therapist's use of self; holding the balance; monitoring and managing arousal; punctuating

or terminating therapist nonmentalizing; monitoring and correction of own mistakes; and highlighting and reinforcing client mentalizing. We end this chapter by introducing the basic process of mentalizing that will be used during every serve-and-return with a client. With these basic components in place, we then move on to specific mentalizing interventions, which we discuss in Chapter 8.

The goal of Chapter 8 is to build on the knowledge gained in Chapters 6 and 7 to introduce you to the affect pyramid, which depicts the spectrum of mentalizing interventions you will use, depending on the level of your client's in-the-moment emotional arousal. You will learn that there are four levels in the spectrum of interventions: empathic validation, clarification and affect elaboration, contrary moves, and mentalizing the relationship. As in the other intervention chapters, we will use the case of MJ to illustrate how these interventions might play out in a session with a client.

Chapter 9 will leave you with some closing thoughts on supervision, working in teams, and where and how to get additional mentalization-based training. It will also provide you with a self-assessment to help you reflect on what you have learned. Recall that our overarching goal with this book was to offer a practical starting point for incorporating the Mentalizing Stance into your therapeutic work, regardless of orientation. In following the guidance we provide in this book, you can enhance your mentalizing in your interactions with your clients, as well as your interactions with others in your daily life.

We aim to avoid, wherever possible, the kinds of highly technical psychological language that pervade descriptions of mentalization-based working. While some of these concepts (e.g., psychic equivalence, pretend mode, prementalizing modes) have to be used in order to stay true to the framework, we have gone to great lengths to simplify their meaning. Many trainees have reported finding such language off-putting, and this has been a barrier to the dissemination of these highly pragmatic and useful ideas into areas of practice where they could be of real use. Thus, where necessary, we will at the least try to translate such concepts and phrases into language that is more accessible to readers from other intervention backgrounds.

As we wrote this book, we imagined we were talking to our students and trainees, helping them come to an understanding of what mentalizing is and how it can serve to improve their relationships with

their clients, and consequently, the relational lives of their clients. We will therefore include several pedagogical features in the form of diagrams, graphs, and tables to explain concepts and processes. Throughout the text we have bolded important concepts that form the core intellectual structure of mentalizing theory and practice. So whenever you see a **bolded** word, pay attention, because the word is likely to pop up again and again, and understanding its meaning will be important. Bolded words have also been included in "Key Terms and Concepts" at the end of the book so that you can easily refer back to these central concepts. For clinicians wishing to use this book to disseminate mentalization-based therapies to their students, trainees, and treatment teams, we encourage you to use the self-assessment material provided in Chapter 9 as an outcome measure. Throughout the book, you will notice that we include transcripts of sessions with MJ, highlighted in text boxes, to make clear how the Mentalizing Stance and intervention play out in real time.

A WORD ABOUT LANGUAGE AND CASE MATERIAL

To reiterate, the discussion in this book is not tied to any particular treatment approach. The Mentalizing Stance is applicable to any form or school of psychotherapy. Though many ideas supporting the Mentalizing Stance derive from psychoanalytic theory and research, we have avoided field-specific jargon as much as possible. To be optimally representative, we alternate gendered singular pronouns throughout, with the exception of specific case examples. The clinical examples in the book (including the case of MJ) are fictional, and do not depict any actual persons.

ACKNOWLEDGMENTS

For the last 15 years we have been on an incredible journey learning to understand mentalizing, learning how to mentalize ourselves, and learning how to teach mentalizing. We hope that by demystifying this basic human capacity, we can enrich the lives of clinicians and the individuals and families with whom they work. This book is dedicated to our patients and students, who are the best of teachers, and often the most forgiving too.

Contents

CHAPTER 1	Setting the Stage for Mentalizing	1
CHAPTER 2	What Is Mentalzing?	16
CHAPTER 3	How Does Mentalizing Develop?	40
CHAPTER 4	Difficulties in Mentalizing . . . and Difficulties in Learning	63
CHAPTER 5	Mentalizing Assessment and Formulation	84
CHAPTER 6	MBT Structure	103
CHAPTER 7	The Mentalizing Stance	117
CHAPTER 8	Mentalizing Interventions	148
CHAPTER 9	Going Further with the Mentalizing Stance	177
	Key Terms and Concepts	185
	References	193
	Index	203

CHAPTER 1

Setting the Stage for Mentalizing

Mentalization-based approaches to therapy constitute an integrative form of psychotherapy, bringing together aspects of psychodynamic, cognitive-behavioral, systemic, and ecological approaches. Mentalization-based therapy (MBT) was first developed and manualized by Peter Fonagy and Anthony Bateman, and is designed to target mentalizing impairment associated with poor relationship and personality function. Since the original MBT manual, many other mentalization-based clinicians and scholars have built on the work of Bateman and Fonagy, resulting in an enormous proliferation of mentalization-based adaptations and expansions over the last 10–15 years. Mentalization-based approaches have been highly successful in bringing psychodynamic thinking back into the mainstream and integrating it into other approaches such as the CBT and dialectical behavior therapy (DBT) approaches. With several randomized controlled trials under its belt, as well as naturalistic outcome studies, in addition to regular MBT workshops across the globe and several published treatment manuals, MBT is now recognized by experts as one of the major treatment approaches to personality disorder in adults and adolescents (Cristea et al., 2017; Storebo et al., 2020), with strong emerging evidence for treating a variety of other conditions.

Despite the popularity of the construct of mentalizing and the status of MBT as an evidence-based treatment, acceptance of mentalization-based approaches has been slower than that of cognitive-behavioral approaches, especially in the United States, where there is a stronger emphasis on skills-based psychotherapies. Perhaps because

of its psychoanalytic roots and jargon, the construct and theory have sometimes been described as obscure, making it hard to teach mentalizing therapies to novice therapists—especially those from a nonpsychoanalytic or nonpsychodynamic background. Part of the challenge is the fact that mentalization-based interventions, by design, abandon specific techniques in favor of a **generic therapeutic stance** that cuts across therapeutic modalities. Thus, mentalization-based approaches have been criticized for being too abstract and relying heavily on expert supervisors who can translate dense psychodynamically based theory into practice. We have heard trainees and novice therapists ask these questions: "What does mentalizing mean exactly?" "Are mentalizing and **theory of mind** interchangeable terms?" "How does mentalizing relate to empathy, mindfulness, and emotion regulation?" "What is meant by **psychic equivalence**?" "As a therapist, how do I know when I'm mentalizing? And how do I know when my client is not mentalizing?" "I know I'm supposed to take a Mentalizing Stance, but how do I do that? What do I say? What do I do?"

Over the years, we have also heard supervisors ask: "How can I teach my treatment team to mentalize? They have no psychoanalytic or psychodynamic background." "How can I teach my students MBT? Because they are novices, they cannot draw on their psychotherapy experience to understand the relational basis of MBT. I need a way of explaining the basics of mentalizing in easy terms!"

This book is geared primarily toward answering these questions. We aim to demystify mentalizing treatment by communicating its essentials to the reader in simple terms. In our experience, the Mentalizing Stance *can* be successfully taught and learned. Importantly, mentalizing can be incorporated into any therapeutic modality. This is because all therapists mentalize! What you will learn in this book is how to do more of it.

In this opening chapter, we set the stage for the chapters to come. We first introduce you to the general therapeutic orientation required for incorporating a mentalizing approach into your work. Next, we explain why it is that mentalizing can be incorporated into any therapeutic modality. You will see that this is because mentalizing lies at the basis of all successful interpersonal interactions, including the therapeutic interaction. Mentalizing is therefore a common factor that is relevant across therapeutic modalities. Its enhancement therefore benefits all therapy—and for that matter, all interactions.

A THERAPIST REORIENTATION

Incorporating a Mentalizing Stance into your work requires a **therapist reorientation.** The critical reorientation needed for mentalization-based work is to let go of an authoritative stance. Many well-trained and highly experienced therapists and mental health workers have worked years and years to become an authority on mental health and intervention. They become specialists in a particular condition or population and use well-designed treatment manuals specifically designed and evaluated for just that disorder or population. The question is why a therapist schooled in a particular treatment manual would want to integrate a Mentalizing Stance into her work—especially if she learns that mentalizing is all about not-knowing. After all, there is immense security and comfort in feeling that you *know* what you're doing; that you are an authority in your field—an expert with the qualifications to show for it.

At the other end of the spectrum, let's consider for a moment the novice therapist or mental health worker with less therapy training. Learning to do therapy for the first time is highly anxiety provoking. Novice therapists often have little hands-on experience with real patients before they do their first therapy sessions; and often, therapy sessions are video recorded for later supervision, further increasing anxiety. Equally, becoming part of a mental health team that carries shared responsibility for the well-being and survival of another human being is incredibly anxiety provoking, regardless of level of experience and training background.

> *Mentalization-based work requires letting go of an authoritative stance.*

Thus, we see at both ends of the experience continuum that the reliance on manualized and highly circumscribed evidence-based treatment manuals developed with a particular disorder in mind brings comfort, security, and reduced anxiety. Clinicians follow the guidance summarized in the manual for treating the disorder and find comfort in the thought that if they adhere to the model, their patients will get better, just as in the randomized controlled trial that established the therapy. However, as we will discuss below, the limitations of these circumscribed approaches to mental health problems have become more and more apparent over the last decade or so, calling

for innovation based on the most recent science in understanding the nature of mental disorders and their treatment.

Against this background, and based on our experience in training novice therapists in a clinical psychology PhD program (Sharp) and treatment teams (Bevington), we became aware of the need for a simple, straightforward introduction to mentalization-based approaches that can facilitate the reorientation needed to forgo an authoritative stance in favor of a Mentalizing Stance, regardless of therapeutic modality. In thinking about how to facilitate this reorientation, we have heeded the feedback from MBT implementation studies (e.g., Hutsebaut et al., 2012) showing that while therapists were trained in the mentalization-based model, read the books and manual, and received classic supervision by experienced trainers, they still felt insufficiently prepared to apply their new knowledge and skills to deal with changing everyday situations in their setting. Concrete protocols were asked for, specifically in terms of how to apply the mentalization-based model in order to reduce uncertainty and anxiety. There is a natural tension here because as we will show in the rest of this book, mentalization-based therapies are designed to enhance uncertainty! So how do we help clinicians to move away from the urgency and need for **certainty**? And why is it important to do so? Moreover, mentalizing approaches emphasize the development of an attachment relationship with patients, staying mentally and emotionally close even in times of crisis and adopting a **not-knowing stance**. They require a level of transparency from therapists unlike other models as well as a focus on affect within the therapist–patient relationship; therefore, a particular set of personality characteristics is required for successful MBT therapists. These include, as other MBT manuals suggest, openness, high cognitive flexibility, intellectual humility, low rigidity, adaptability, and high tolerance of uncertainty. The question is, how does one learn the *attitudes* that embody the Mentalizing Stance? In short, how do we teach people to mentalize?

As you will see, in this book we aim to distill the core features of the Mentalizing Stance. Based on the information that we provide, you will be able to incorporate a Mentalizing Stance into your work, regardless of treatment modality. You can use it before or while you undergo mentalization-based basic or advanced training to translate and consolidate some of what you are hearing throughout your

training. The book can also be used as an introduction to mentalization-based theory and practice to help you decide whether you want to peruse additional manuals and/or workshops for more specialized training. Further, you can use this book in your own teaching as you introduce others to or train them in mentalization-based approaches.

We want to emphasize, though, that we have written this book to stand on its own—that is, our goal is for you to be able to use what we convey in this text immediately in your everyday practice. In fact, when we train students, we encourage them to begin **flexing their mentalizing muscles** not only in everyday practice, but in everyday life. As we will elaborate below, mentalizing is a dimensional construct—that means it is useful across the full continuum of healthy (typical) to unhealthy (atypical) relationship and self functioning. The more you do it, the better you get at it. So we encourage readers to begin incorporating the Mentalizing Stance into the **serve-and-return** of their own interactions in everyday life. It will make you a better spouse, partner, parent, friend, and coworker—we guarantee it!

Before jumping into the ensuing chapters and the specifics of mentalization-based therapy, we want to pause for a moment to come back to the question of why therapists and other mental health clinicians, regardless of treatment modality, should consider integrating a Mentalizing Stance into their work. Why give up the comfort and security of an authoritative stance?

THE GREAT PSYCHOTHERAPY DEBATE

As chronicled in Bruce Wampold's book *The Great Psychotherapy Debate* (2015), cognitive and behavioral therapeutic approaches began to be promoted as the best empirically supported approach to alleviate psychological suffering in the wake of valid concerns raised in the 1960s and 1970s regarding psychotherapy approaches that were ineffective at best, and harmful at worst. So successful was the cognitive-behavioral therapy (CBT) revolution that by 2012, 45% of clinical psychologists in the United States reported that their primary rotation was either cognitive or behavioral versus 18% psychodynamic, 22% eclectic/integrative, and 14% humanist, systems, or interpersonal (Norcross & Rogan, 2013).

The rise of cognitive-behavioral approaches coincided with two

other important movements. The first was the move away from a psychoanalytically informed psychiatric nosology as represented in the first and second editions of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM-I and DSM-II) toward a more descriptive psychiatric nosology as espoused by DSM-III, which was justified by the field's concerns over the validity and reliability of psychiatric diagnoses as summarized in DSM-I and DSM-II. Those leading the efforts toward DSM-III advocated for a psychiatric classification system in which the symptoms or disorders were more observable and measurable in the same way that signs and symptoms of physical conditions can be observed and measured. As opposed to DSM-I and II, which contained brief narrative descriptions of each diagnosis and category, DSM-III contained diagnostic criteria including observable behaviors and self-reported symptoms, with specific symptom thresholds for determining whether the disorder is present and exclusion criteria for determining when an individual could not have a disorder. Each diagnosis also contained a description of the typical demographics of an individual with that disorder, a narrative explanation of how to obtain a differential diagnosis, and a narrative summary of what was known about the disorder's etiology and development. DSM-III was also atheoretical, which means it did not adhere to any one theory about the development of psychopathology (e.g., psychoanalytic, behavioral).

However, with each diagnosis containing its own unique set of descriptors and correlates, the unintended consequence was what since has been referred to as "splitting" (as opposed to "lumping") of disorders. Whereas DSM-I contained 128 diagnoses, DSM-5 contains 541 diagnoses organized into 22 diagnostic categories. And because each diagnosis is associated with its own unique descriptors and correlates, they are viewed as categorically distinct from each other, while in actual fact, clinicians are well aware of the high level of comorbidity across disorders and heterogeneity within disorders. Especially with regard to conditions like personality disorders, it is rare to find an individual with, for instance, borderline personality disorder (BPD), who does not also meet criteria for depression, anxiety, substance use disorder, and one or two additional personality disorders.

The splitting of disorders into apparent categorically distinct conditions led to the second movement coinciding with the rise of

cognitive-behavioral therapies, and that was the notion that each disorder should be treated with its own evidence-based treatment manual established in the context of a randomized controlled trial. Like nosological reform, this movement was well intentioned. The idea was that in the same way that we would refrain from using diabetes medicine to treat someone with cancer, we would refrain from treating someone with substance use disorder with depression treatment. This goal was to be achieved by standardizing treatments through manualization, after which standardized treatments could be tested and compared in the gold-standard randomized controlled trial. The manual was intended to reduce variability in the treatment—that is, standardize the treatment across therapists and patients—as this is the only way that the specific active ingredients of the treatment could be identified. So impactful was the manualization effort that it became compulsory for clinical trial grant applications to include a copy of the manual or at least provide a session-by-session description of the exact and concrete operations that the therapist will perform to stay adherent to the treatment. Further compounding the manualization of psychotherapy was the managed care movement of the 1990s, which allowed insurance payments for diagnosis-related groups only if the diagnosis was considered valid and if the treatment had demonstrated efficacy. A set of criteria evolved that set the standard for when a therapy is considered efficacious, mirroring the criteria for drug trials. In short, the criteria stated that a psychotherapy would be deemed empirically valid for a particular disorder if at least two studies showed superiority for the treatment compared to a control condition and were administered to a well-defined population using a treatment manual. Of course, the problem, again, is that psychiatric disorders often co-occur, and the boundaries between disorders are not as clear-cut as the boundaries between physical conditions.

Fast-forward to today, and we have come full circle—we are now fully aware of the unintended consequences of the movement toward evidence- and empirically based manualized practice, which are out of step with the most cutting-edge science on the nature of psychopathology and its treatment. To elaborate, we will discuss below some of the most exciting facts we now know after 50 years of psychopathology and psychotherapy research. Together, these facts build a strong rationale for moving away from treatment manuals for circumscribed categorically defined diagnoses in favor of common-factor,

transdiagnostic treatment approaches such as mentalization-based therapies.

PSYCHIATRIC DISORDERS ARE NOT CATEGORICAL ENTITIES, BUT RATHER DIMENSIONAL CONSTRUCTS

Whereas 50 years ago a need was identified to split disorders into categorically distinct entities, we now know that psychiatric disorders are best characterized dimensionally. Dimensionality implies, first, that individuals are neither "normal" nor "abnormal" but lie on a continuum that demonstrates not only between-person differences (we call these individual differences), but also within-person differences over time. For instance, in the context of BPD, we know a person may be a bit more borderline one month compared to another month, depending on what is happening in the person's life. An individual may be moving in and out of the diagnostic threshold, which means the categorical diagnosis may be misleading depending on when we assess or work with the individual.

Second, dimensionality implies that individuals with subthreshold symptoms (that is, below the defined cut-off to fully meet criteria for a psychiatric disorder) may be experiencing as much distress as someone who is on the other side of the diagnostic threshold. Put differently, a person with four out of nine criteria for BPD would be considered as not meeting criteria. However, this individual may be experiencing the same level of distress as someone who has five out of nine symptoms (meeting diagnostic threshold).

Third, dimensionality implies that the co-occurrence of traditional disorders is best explained by "common factors" or dimensions that underlie their co-occurrence. For instance, we know most individuals with high levels of depressive symptoms also tend to have high levels of anxious symptoms. Therefore, their problems are best described by the shared or common features between anxiety and depression, which turns out to be negative emotionality—a temperamental trait also referred to as neuroticism.

Take-Home Message: The implications of dimensionality for treatment are clear. Instead of delivering separate treatment manuals consecutively for different disorders, it may be more effective to treat the transdiagnostic (common) dimensions underlying the

shared features of psychopathology. In the case of anxiety and depression, research has shown this underlying factor to be negative emotionality. Barlow's Unified Protocol for Transdiagnostic Treatment of Emotional Disorders (Barlow et al., 2017) is a good example of a treatment approach designed to address common features. As we will argue, the mentalization-based therapies address another important common feature shared by all personality pathology, and even other forms of psychopathology—that is, **self and interpersonal function**.

PERSONALITY DISORDERS DO NOT EXIST IN THE WAY WE ONCE THOUGHT THEY DID

The dimensionality research has also heavily impacted the way we understand personality disorders. For instance, readers who are familiar with the most recent edition of the DSM (DSM-5; APA, 2013) will be aware that personality disorders are listed alongside other psychiatric disorders in Section II. There, you will find the 10 traditional, categorically defined personality disorders (Paranoid, Schizoid, Schizotypal, Antisocial, Narcissistic, Borderline, Histrionic, Dependent, Obsessive–Compulsive, and Avoidant). However, many researchers have conducted studies in which they entered all the symptoms of personality disorder into a factor analysis to verify the existence of 10 distinct personality disorders. Studies by and large failed to demonstrate a 10-factor covariance structure underlying personality disorder symptoms. Instead, the symptoms of various personality disorders were found to cross-load onto each other so that there really was no evidence for 10 distinct disorders.

MBTs address self and interpersonal function.

A more empirically valid way of conceptualizing personality disorder is similar to IQ. In 2015, with Lee Anna Clark and Aidan Wright, we published a paper in the *Journal of Abnormal Psychology* (Sharp et al., 2015b), in which we allowed symptoms of personality disorder to load onto both a general factor of personality disorder (now known as the *g*-PD) and specific factors (flavors or types of personality pathology). The results showed a clear general factor of personality pathology—just like the general factor of

intelligence captured in the construct of IQ. This means that we can think of people as lying on a single continuum of personality function similarly to IQ. We can therefore ask what a person's personality pathology quotient is, instead of needing to fit people into personality types or disorders for which we have little empirical evidence. Interestingly, while our study showed that specific factors (flavors or types) emerged for narcissism, avoidant, obsessive–compulsive, schizotypal, and antisocial flavors, BPD symptoms loaded exclusively onto the general factor of personality pathology. This suggests that BPD, all along, may have been a relatively good proxy for the maladaptive self and interpersonal features shared by all personality disorders. This is an idea that Otto Kernberg articulated when he introduced the notion of borderline personality organization in the 1960s to capture a level of personality function that lies somewhere between neurotic disorders (such as depression and anxiety) and psychotic disorders (such as schizophrenia) (Kernberg, 1967).

Our data (which have been replicated many times since 2015) fit well with the most cutting-edge conceptualizations of personality disorder. For instance, in Section III of DSM-5 you will find the Alternative Model for Personality Disorder (AMPD). Consistent with the Sharp et al. (2015) study, the DSM-5 work group recommended that the 10 categorically defined personality disorders be abolished in favor of a new classification system in which a clinician assesses the *g*-PD of personality function in the form of Level of Personality Functioning (LPF), or Criterion A of the AMPD. Readers interested in the LPF are encouraged to read a full and detailed account of it in Sharp and Wall (2021). In short, LPF is a unidimensional severity criterion that captures what is common and shared among all personality disorder flavors. When assessing LPF, the clinician assesses personality function across five levels of severity with 0 = typical personality function and 4 = severe impairment in personality function. Personality function is defined in terms of self and interpersonal functioning and is assessed across four domains: identity, self-direction, intimacy, and empathy. After the clinician has assessed the LPF, he or she then moves on to Criterion B, which describes five maladaptive trait domains (negative affect, detachment, psychoticism, antagonism, and disinhibition), which partially correspond with the pathological "poles" of the five-factor model of basic personality, and

map on well to the traditional personality disorders. Finally, the clinician can then review the combination of Criterion A and B function and decide whether the patient meets criteria for a specific personality disorder like BPD.

Many of us in the field believe the assessment of maladaptive self and interpersonal functioning as captured in the LPF is necessary and sufficient for the diagnosis of personality dysfunction. In fact, in the new ICD-11 system, which has become operational in 2022, diagnosis of maladaptive traits (Criterion B) has been made completely optional, and a person may be diagnosed as personality disordered purely based on maladaptive self and interpersonal function. Moreover, the 10 traditional categorical disorders have been completely abolished from the ICD-11. We have argued (Sharp & Wall, 2021) that while the Criterion B and C "flavors" of personality disorder (the maladaptive traits) provide useful additional descriptive value, they are not necessary for treatment planning, especially if your treatment approach is focused on common, transdiagnostic features of psychopathology like self- and interpersonal function. In other words, if your treatment approach is designed to address the shared and common features of personality pathology, that is, maladaptive self and interpersonal function, your treatment will result in productive outcomes without having to resort to any specialized manual geared toward the flavor or type of disorder. While nothing stops a clinician from addressing the flavor or type of disorder later on, doing so without addressing the common or shared features of psychopathology will likely be unproductive. We have seen evidence of this in many treatment outcome studies where individuals with personality disorder are treated for their anxiety and depression with specialized treatment manuals, but their personality functioning does not improve until they are treated with an approach that focuses on overall personality function (that is, maladaptive self and interpersonal function). Importantly, while their anxiety and depression symptoms improve, their functional outcomes and quality of life typically do not—again drawing attention to the importance of addressing underlying, common, transdiagnostic features in therapy.

Take-Home Message: The mentalization-based therapies were developed specifically to address self and interpersonal function (i.e., the

common features of personality function). They may therefore offer a more efficient way of treating the aspects of disorder that bring people to the consultation room most often: their challenges in self and interpersonal function. They are essential and conditional for the treatment of personality pathology.

COMMON FACTORS IN PSYCHOTHERAPY ACCOUNT FOR THE LARGEST EFFECT SIZES IN TREATMENT RESPONSE

As articulated by Wampold and Imel (2015) in their summary of psychotherapy treatment outcome studies, there are several common features shared by all psychotherapies that individually, and combined, account for the largest effect sizes in treatment response. The most researched common factor is of course the therapeutic alliance (quality of the therapeutic relationship) between therapist and client. Meta-analytic studies have shown that the relationship between therapeutic alliance and treatment outcome is about .28 (Fluckiger, Del Re, Wampold, & Horvath, 2018), which translates to a moderate effect size of .58. About 5–9% of the variance in treatment outcome is explained by therapist factors, which compared to other factors constitute the largest proportion of explained variance in treatment outcome. Therapist factors seem to explain more variance than (1) the variability between treatments (0–1%), (2) evidence-based treatments versus placebo (0–4%), and (3) the alliance (5%) (Duncan, 2010; Lutz, Leon, Martinovich, Lyons, & Stiles, 2007). When we ignore the effect of the individual therapist, we erroneously attribute the effectiveness—or lack thereof—to the specific treatment (Bo, Sharp, Luyten, Kongerslev, & Fonagy, in press). Schiefele et al. (2017) reported that the average recovery rate for the more effective therapists is almost twice that of the less effective group. So what are these therapist effects that appear so powerful in predicting treatment outcome? A recent systematic review (Heinonen & Nissen-Lie, 2020) has shown that professional self-doubt (sometimes referred to as humility or modesty) may be beneficial to patient outcomes, especially when treating severe psychopathology. For instance, effective therapists report having made more mistakes than ineffective ones. In addition, the familiar Rogerian qualities have been replicated in many meta-analyses as predictors of good outcomes, including empathy,

warmth, and positive regard, clear and positive communication, and the capacity to manage criticism.

Take-Home Message: Research shows that treatment approaches with a primary focus on enhancing therapeutic alliance and therapist characteristics may be the most effective. Mentalization-based therapies, which are by design relational, teach these characteristics through the Mentalizing Stance.

FACTORS OUTSIDE THE THERAPY ROOM EXPLAIN THE LARGEST PROPORTION OF VARIANCE IN PSYCHOTHERAPY OUTCOMES

Wampold and Imel (2015) attribute about 86% of variance in outcomes to extra-therapeutic factors—that is, factors outside the therapy room. The high attribution of outcome in psychotherapy to extra-therapeutic factors is also reflected in findings showing that whether you engage in therapy or not explains only 14% of the variance in the outcome (Bo et al., in press; Wampold & Imel, 2015). Extra-therapeutic factors mostly include factors to do with what Freud famously coined "love" and "work"—that is, what happens in a person's home and work/school environment, which also may include the broader community and feelings of social support. Extra-therapeutic factors also include the stressful events that may occur in a person's life and other environmental factors that interfere with a person's capacity to cope.

Take-Home Message: The powerful influence of extra-therapeutic factors points to the importance of employing a therapeutic approach that provides an individual with the ability to effectively make use of the social environment in times of stress. Such a therapeutic approach must provide an individual with the capacity to **learn from others,** to take advice from others, to allow others to support them, and the ability to make sense of what is happening to them. As we will argue, the mentalization-based approach offers individuals a way of learning how to effectively make use of the natural attachment and social network around them.

Mentalization-based approaches guide clients to make use of the social network around them.

THE TRANSDIAGNOSTIC MECHANISM OF CHANGE IN MENTALIZATION-BASED APPROACHES

Elsewhere (Bo et al., in press) we have articulated the point that all structured therapeutic treatment programs have a treatment frame that includes a model of mind, a model of the disorder, and an intervention strategy that is presented to the patient (Bateman, Campbell, Luyten, & Fonagy, 2018). In this regard, mentalization-based therapies articulate a basic mechanism of change that can explain effectiveness common to all treatment: that is, the use of ostensive cueing to increase **epistemic trust** (or conversely, the lowering of **epistemic hypervigilance,** see below) and enhance social learning, which together set the stage for therapeutic change. Let's unpack this statement a bit.

Ostensive cues signal that communication not only transfers information, but also that it is intentionally transferred to the recipient (Csibra & Gergely, 2009). The therapist **puts her mind on the table** to make clear her intentions for communicating a particular piece of information. In so doing, the therapist's mind becomes less opaque to the client and the client begins to understand why the therapist raises a particular point. Critically, the therapist signals that her mind is different from that of the client and that both minds hold equally important perspectives. The therapist does not speak as an authoritative figure who *knows* the deficiencies of the patient. Neither does she speak as a cheerleader, blindly cheering on her patient. Instead, she declares what is on her mind in relation to the patient and thereby signals a gap between her understanding of the patient's mind and what the client may present. This gap offers a **collaborative learning opportunity** to the patient. As such, ostensive cues are essential for information to be trusted, and they in turn activate a pedagogical stance for learning about new information that leaves the recipient with a sense of being acknowledged and understood as an agentive self (Gergely, 2008)—one who operates upon the world (as an "agent"), holding a reasonable expectation that these operations will result in reasonably predictable outcomes. Consequently, epistemic trust is enhanced and refers to the capacity to identify knowledge conveyed by others as personally relevant and generalizable to other contexts (Fonagy, Luyten, & Allison, 2015). Thus, by feeling understood, the client experiences epistemic trust in the

therapist: the belief that the therapist is conveying information worth knowing. Conversely, epistemic hypervigilance is a mode of mistrust that obstructs learning. Mentalization-based therapies follow, therefore, in essence, a social learning paradigm of psychotherapy process that holds that all evidence-based therapies must meet the client with acknowledgment and curiosity about her experiences and perspectives (which fairly well encapsulates the Mentalizing Stance). It is for this reason that mentalizing has been suggested as a common factor for treatment in general, and of BPD treatment in particular—because it activates the social context from which the client learns, not only in the therapy room but also outside of it. If all of this sounds hard to grasp at this stage, do not worry. You can summarize what we are saying by considering a kind of virtuous cascade: from mentalizing and ostensive cueing by a helpful mind, to openness to learning and epistemic trust in one wanting help, and from there on to generalization out in the social world and feedback from enriched social connections. We will return to all of these concepts throughout the book.

CHAPTER SUMMARY

In this chapter we have built the rationale for mentalization-based therapies by emphasizing the importance of addressing common factors across disorders and therapeutic modalities—especially those that have to do with maintaining rewarding and productive relationships. We have put forward the idea that for this reason, a Mentalizing Stance can be incorporated into any therapeutic modality because it will enhance the quality of interactions between therapist and client—and clients and their loved ones—regardless of other goals and techniques in treatment. We emphasized that our goal in this book is to demystify **mentalizing interventions** by distilling their core features using straightforward language and examples.

CHAPTER 2

What Is Mentalizing?

In Chapter 1 we communicated that we have only one central goal in this book, which is to teach you the Mentalizing Stance. From the Mentalizing Stance, all good things will follow. We therefore spend a whole chapter just based on the definition of the construct. If you fully understand the construct, you will be able to mentalize (and you will realize that, in fact, you already could).

So what do we mean by "mentalizing"? Mentalizing has been defined as "a form of imaginative mental activity, namely, perceiving and interpreting human behavior in terms of intentional mental states (e.g., needs, desires, feelings, goals, purposes, and reasons)" (Fonagy, Gergely, Jurist, & Target, 2002), which consciously or unconsciously enables us to perceive and interpret human behavior in terms of intentional mental states (Allen, Fonagy, & Bateman, 2008). Several points are important to note. First, mentalizing is something that we do; it is a verb and denotes an activity. Second, the human behavior of perceiving and interpreting we refer to in the definition includes the behavior of others as well as our own behavior. Thus, we can mentalize ourselves as well as others. Third, mentalizing is about imagination. As we will explain later, mentalizing celebrates the uniquely human capacity for imagining counterfactuals, alternative realities—past, present, and future. And finally, mentalizing is about intentionality—knowing that acts don't appear randomly but

that we make meaning out of them by referring to reasons that may lie behind them. To further elaborate on these concepts, we begin with a brief history of the concept of mentalizing.

A BRIEF HISTORY OF THE CONCEPT OF MENTALIZING

The concept of mentalization has been used in psychoanalytic literature since the 1960s (Allen, 2003; Marty, 1991; Marty & M'Uzan, 1963). It refers to the process of mental elaboration, including symbolization, for the transformation and elaboration of drive-affect experiences as mental phenomena and structures (Lecours & Bouchard, 1997). If this definition sounds a bit dense to you, and you are not fluent in the language of psychoanalysis, do not fear. We offer this definition of mentalizing simply to give you a sense of its psychoanalytic roots. What this complex sentence means in plain language is that mentalizing involves the process by which we mentally expand the meaning we give to experiences. We create a mental representation of an experience as it has happened, in a context, which we can reflect on and communicate to others. We also keep the representation in our memory and change it as time goes by. Human beings actively make meaning out of their experience, and this meaning-making is subjective, so two individuals may experience the same event but construct completely different representations of it.

Mentalizing is about imagination.

In the 1980s and 1990s the construct of mentalizing was incorporated into mainstream neurobiological and developmental literature (Frith, 1992; Morton, 1989). If you read this literature, you will see that the term was (and sometimes still is) used interchangeably with the concept of theory of mind (ToM). In fact, the two terms are not interchangeable. ToM was coined by Premack and Woodruff (1978), who were primatologists working with chimpanzees. In their landmark experiment, they showed an adult chimpanzee a series of videotaped scenes of a human actor struggling with a variety of problems. Some problems were simple, like bananas being placed vertically or horizontally out of reach. Other problems were more complex, involving an actor unable to extricate himself from a locked cage, or shivering because of a malfunctioning heater. With each videotape

the chimpanzee was given several photographs that contained a solution to the problem, such as a stick for the inaccessible bananas or a key for the locked-up actor. Premack and Woodruff found that the chimpanzees consistently chose the correct photographs, thereby demonstrating that they recognized the videotape as representing a problem, understood the actor's purpose, and chose alternatives compatible with that purpose. The chimpanzees appeared to understand that the actor had intentions—that is, the actor had a problem, and with problems come the intention to solve them. In other experiments, Premack and Woodruff showed that chimpanzees had the capacity to deceive. If you think about it carefully, you can only deceive another person if you have a solid understanding of the wrong (false) belief that your "victim" must hold. In short, Premack and Woodruff put forward the idea that chimpanzees had minds.

The work of Premack and Woodruff influenced philosophers of mind like Daniel Dennett (1978) to suggest a paradigm/experimental task for studying ToM in humans. This paradigm, which is called the false-belief paradigm, has many versions. In Figure 2.1, we demonstrate one of these versions, the Sally–Ann task, and it goes like this: Sally has a black box and Ann has a white box. Sally has a marble. She puts the marble into her box. Sally goes for a walk. Ann takes the marble out of Sally's box and puts it into her box. Sally comes back and wants to play with her marble. Where will Sally look for her marble? Only when you are able to mentally represent Sally's wrong (false) belief ("The marble is in the black box") apart from what you yourself know to be the case ("The marble is in the white box") will you be able to point correctly to the black box. Because Sally was not in the room when Ann moved the marble she holds the false belief that the marble is still in the black box.

This procedure therefore tests whether an individual has an explicit and definitive representation of the other's wrong (false) belief. Again, as with the chimpanzees, we see that we can decouple mental representation from reality. Your mental representation (or memory of where Sally left the marble) is decoupled from reality (where the marble was moved to by Ann in her absence). You are therefore able to know where the marble really is now, but at the same time hold in mind where it was, which is where Sally thinks it (still) is. That human beings (and chimpanzees!) have the capacity to decouple mental representation from reality is an important point to

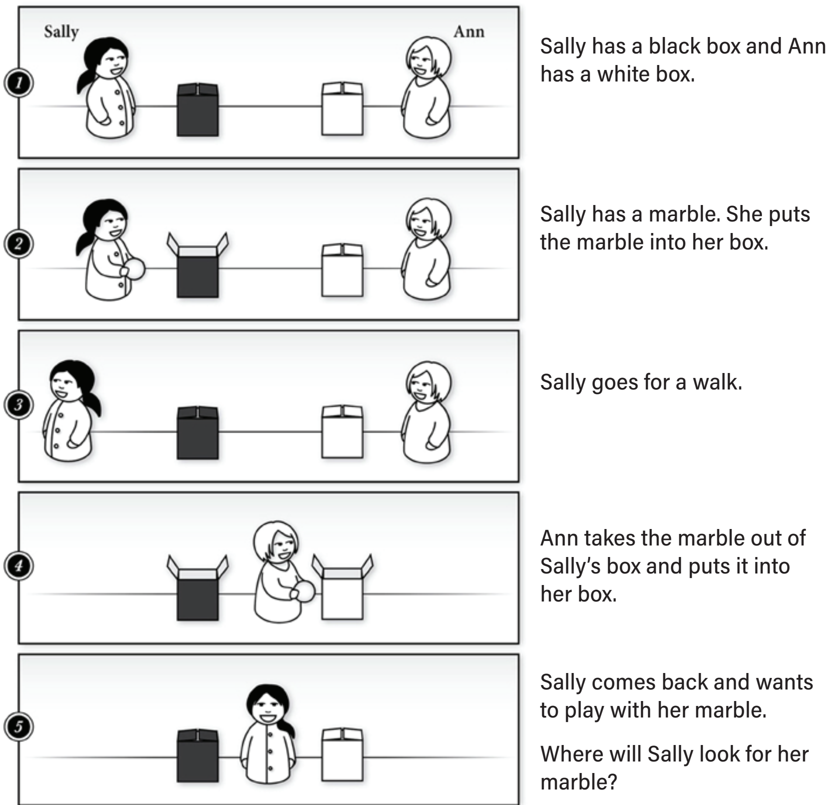


FIGURE 2.1. The Sally-Ann Task. Reprinted from Wimmer & Perner (1983) with permission from Elsevier.

grasp, and one that we will return to again and again in this book. It means mental representations are not simply replicas of reality; instead, your brain changes the meaning of reality in the process of representing it. That is what we mean by "decoupling," and that is where the subjectivity of human experience comes from.

Human beings can decouple mental representations from reality.

The false-belief paradigm came to be known as the "acid test" for ToM capacity. Many versions of this paradigm have been developed since the original work by primatologists and philosophers, most notably by developmental

psychologists like Wimmer and Perner (1983), and by clinical psychologists, such as Baron-Cohen (Baron-Cohen, Leslie, & Frith, 1985). By the 1990s, ToM paradigms became a well-established feature of developmental and clinical psychology, and we began seeing the use of accelerated advances in technologies to enable neuroscientific studies of ToM. Researchers began to use, for instance, functional neuroimaging to study mentalizing in the context of real-time interpersonal interactions. Researchers also began to develop ToM tasks that went beyond the traditional false-belief paradigm. It is at this point in the history of the concept that the concept of ToM was considered to be too narrow to fully capture the scope or representation by the mind. Researchers became aware that the same cognitive capacities that are used to reflect on others' minds (ToM) are also used to reflect on one's own mind. Researchers also felt that the ToM concept became too closely associated with autism research while other psychopathologies were clearly also associated with impairment in the capacity to reflect and represent the world in the mind. Researchers also felt that the concept of ToM became too closely aligned with the false-belief task and wanted to expand the experimental options for this awesome capacity. Thus, researchers began to gravitate toward using the more general term mentalizing to capture this representational capacity—one that includes something of a narrative (how and why person A came to believe X, which explained why he responded as he did in a particular situation, for instance).

An interesting experimental extension beyond the false-belief task has been the use of neuroeconomic or behavioral economic tasks to study the behavior associated with mentalizing. For instance, in collaboration with Read Montague, a neuroscientist, and Peter Fonagy, we had two individuals interact with one another while their brains were being scanned. One of the individuals had a diagnosis of BPD and the other was a healthy control participant. Research participants were asked to play a "trust game" that worked like this (see Figure 2.2): An investor would have 20 points that he or she could send to their partner (the "trustee"). Whatever number of points the investor sent would triple on the way to the trustee. The trustee would then have the opportunity to repay the investor. So if you were playing the game and you were the investor, you might send half of your points over the trustee (10 points), which would

mean that the trustee received 30 points. The trustee might then decide to give you back half of that total. That way, you earned 15 points, bringing your total "holding" to 25 points, and the trustee's to 15 points. On the next round you might decide to give 20 points to the trustee to show you trust that she would send back half. The trustee may then break your trust by keeping the 60 points she receives (leaving you with 5 points, and the trustee with 75). You can see that a lot of mentalizing takes place in this game. Intentions and causes of behavior are attributed to interaction partners, and the ping-pong nature (serve-and-return) of interaction is revealed—that is, my behavior has an effect on your mind, and subsequently your behavior, and so forth.

We published the results of this study in Science in 2008 (King-Casas et al., 2008) and showed that when ruptures in the trust relationship occurred in the game, healthy controls would coax their partners back into the game. This means that healthy individuals would invest larger sums of money on the next round if their partner made a low offer on the previous round. By making a strong offer after being "low-balled" by your partner, you signal that you want to be friends and that you want to work together to resolve any feelings of growing mistrust or competition. The results of the fMRI scan

For 10 consecutive rounds with the same partner:

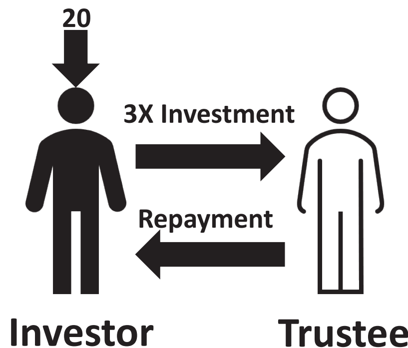


FIGURE 2.2. The Trust Task.

revealed that this coaxing behavior by healthy individuals was associated with increased insula activity in the brain. In contrast, individuals with a diagnosis of BPD would make fewer attempts to repair the relationship. In other words, they did not make attempts to coax back their game partners into a collaborative relationship. This lack of coaxing was associated with the absence of insula activity, with the consequence that both participants in the game lost more points (which directly translated to a financial loss based on payouts after the game). In essence, the borderline brain failed to signal the need to repair the rupture (breaking of trust) that occurred in the relationship during the game.

Mentalizing research has come a long way from its early roots in psychoanalysis, its application in primatology through its connection with ToM, and expansion into social neuroscience. Whether the ability to accurately infer the thoughts and feelings of others is uniquely human or shared with nonhuman primates (and other animals) remains a controversial topic. What we do agree on is that mentalizing lies at the core of our humanity, because without the capacity to reflect on our own and others' mental states, we cannot maintain constructive social interaction, mutuality in relationships, or a robust and integrated sense of self (Bateman & Fonagy, 2012). To carry forward the metaphor of a ping-pong game (serve-and-return): without mentalizing we lose control of the ball, and the game falls apart. The realization of the centrality of mentalizing for optimal interaction accounts for the rise in popularity of the mentalizing construct over the last few decades. Figure 2.3 shows the exponential increase in peer-reviewed papers on mentalization.

Today, nearly 50 years after its first appearance, the concept of mentalization can be found in developmental psychology (attachment) literature and neuroscience, as well as the psychopathology and psychotherapy literature. In this book, we explore mentalizing as it is operationalized within mentalization-based therapies. This therapeutic approach was developed by Peter Fonagy, Anthony Bateman, and their colleagues, and it continues to expand and evolve. The construct of mentalizing and its associated therapeutic approach has at its core flexibility of thought. Therefore, when we mentalize, and when we do mentalizing therapy, we are not boxed in, static, stationary, or set. Instead, we find ourselves in a stance that helps us adapt the social and relational setting for the therapist and a client.

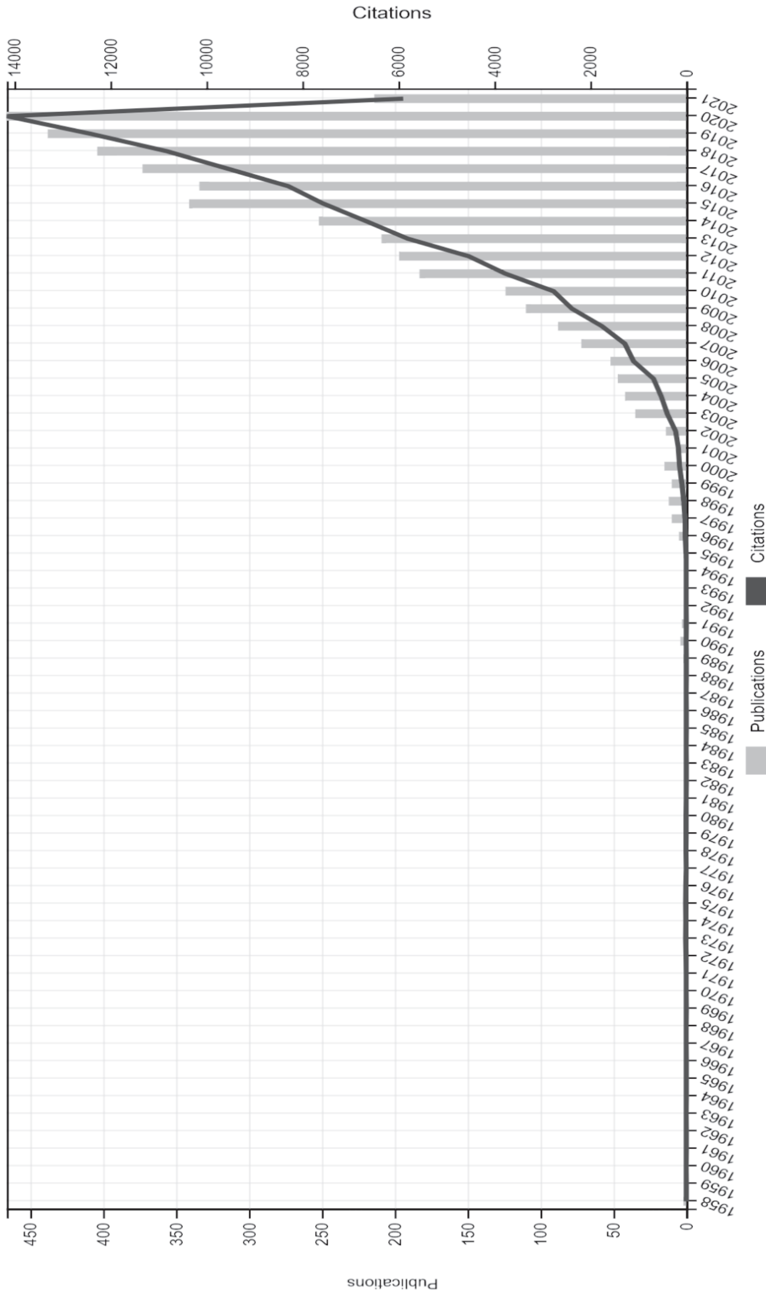


FIGURE 2.3. Published empirical articles on mentalizing, 1958–2021.

Thinking of mentalizing therapies as adopting a specific stance is important in two ways. A stance is a position one deliberately (intentionally) adopts. Rather than merely applying a set of skills, mentalization-based therapy is best understood in terms of the attitude of openness and curiosity we take toward another person. The term stance is useful in a second respect too. In describing the practice of mentalization-based therapies, we speak of a stance rather than a state; a stance is a way of standing, of holding one's balance. Implicit in this is the idea of movement back and forth across the center of gravity, much as a tightrope walker is never stock still, but is in a state of constant dynamic adjustment.

FLEXIBILITY OF THOUGHT: AUTOMATIC-IMPLICIT VERSUS CONTROLLED-EXPLICIT MENTALIZING

In reviewing the history of the construct of mentalizing, we have emphasized that mentalizing is something that happens in the mind. It has something to do with the process of forming mental representations of reality so that what is in the mind is not treated as a direct replica of reality, but as an interpreted and subjective version of reality. Mentalizing has something to do with imagination and intentional mental states, and we mentalize both self and others. Mentalizing is about flexibility of thought and learning. To further elaborate the construct, we would like to introduce you to System 1 and System 2 mental operations, which were developed by cognitive and developmental psychologists (Karmiloff-Smith, 1992), elaborated by neuroscientists (see, e.g., Lieberman, 2007), and then incorporated into MBT (Fonagy & Luyten, 2009, 2016).

System 1 Thinking: Automatic, Effortless, and Often Unconscious

When we mentalize, we imagine what might be going on in the mind of another, while simultaneously imagining (or reflecting upon) our own thoughts and feelings. In this, we are acutely aware that we can never know for certain the content of another's mind or even all the contents of our own minds. While we are actively mentalizing we invariably filter our imagining and reflecting upon the mind through an awareness (you could say an axiom or an assumed truth) that we

can never know for certain the content. You can think of the analogy of electric lightbulbs. Some are clear glass and allow us to see the workings, the glowing filament (or LED these days!) inside, but human minds are more like frosted bulbs; we can see something is going on, but we cannot possibly see what that is. That another person's mind might be opaque (murky) to us seems obvious—after all, we literally cannot read minds. Yet, try to recall the last time you had a disagreement with your spouse/partner and you will see how easy it is to think that you can indeed read minds. See Box 2.1a for an example.

Box 2.1a. System 1 Thinking

WIFE: My darling, did you remember to pick up the dry cleaning?

HUSBAND: Oh no. I forgot. I'm sorry.

WIFE *(feeling annoyed and thinking that he did not really want to do it in the first place)*: Oh no! I need the black dress for tonight's work function. I wish you told me that you weren't going to pick it up and I would have made an effort to pick it up myself.

HUSBAND: I just told you I forgot. I meant to pick it up. I'm really sorry.

WIFE *(remembering the last time her husband forgot to pick up one of the children from soccer practice)*: When I asked you, I just knew you didn't really want to do it. I don't know why I even asked. I could have easily swung by to pick it up if you'd been honest about it. I'd much rather you don't agree to help out if you're not really committing to follow through. At least then I know I need to get it done myself.

If we had the opportunity to interview the wife after the dialogue in Box 2.1a, she would tell us that she cannot peer into her husband's brain or mind, that she is no mind reader. Yet, in the moment she was certain her husband did not really want to pick up the dry cleaning, just as he had failed to deliver on promises in the past. In this example, the wife fails to decouple her mental representation from the reality of the moment. What is in her mind is her reality, and indeed in her mind at that time this is not just her reality but the reality. Now, perhaps if we had more context we would learn that her husband has indeed dropped the ball on many occasions and that she is right in her assumption that he did not really want to pick up the

dry cleaning in the first place. The question is, however, what would be gained by acting upon these assumptions? Does the verbal expression of these beliefs foster a closer relationship between her and her husband, or is there another way (a mentalizing way!) to interact that may ultimately benefit the quality of their relationship in a more profound way? Here, of course, we assume that the couple still share the goal of an intimate, loving, and supportive relationship—we will return to goals and values later in the chapter.

If other minds are opaque to us, surely our own minds are accessible to us? We might not know for certain what our spouses, children, students, or patients think, but surely we know what we think and feel? It turns out that our own minds are as opaque to us as the minds of others. The work of Nobel Prize–winning psychologist Daniel Kahneman and his colleague Amos Tversky has contributed significantly to our understanding of how irrational we are when it comes to our own thinking. Kahneman (2013), describes many of the heuristics (mental shortcuts) and biases humans engage in, which often result in misinterpretations and cognitive errors. Our minds (or brains) are programmed to take these shortcuts because it is more efficient to do so. Taking these shortcuts means we follow our intuition or what cognitive scientists refer to as automatic and often unconscious thinking (System 1 mental operations). This type of thinking is effortless, and we do it on autopilot because it is supported by our associative memory. For instance, when I move in behind the wheel of my car, a whole set of associated cognitive nodes are activated based on prior experience of driving. Kahneman talks about associative coherence—the notion that "everything reinforces everything else." Thus, our associative memory reinforces existing patterns of association and deliberately discounts evidence that contradicts them. Kahneman explains that System 1 settles into a stable representation of reality, which is in and of itself not a flaw but a marvelous accomplishment. However, he also points out that coherence has its cost. Coherence means that you're going to adopt one interpretation and that any ambiguity will be suppressed. That ideas activate other similar ideas, means that the more coherent they are, the more likely they are to activate each other. Alternatives that don't fit fall by the wayside. We're enforcing coherent interpretations. We see the world as much more coherent than it really is.

Reflecting again on the wife and husband scenario in Box 2.1a, we see that the wife relies solely on her intuition to guide her

interpretation of her husband's behavior. She unconsciously constructs meaning from the situation that fits with prior experience and which discounts at least two statements pointing to a different in-the-moment reality ("Oh no. I forgot. I'm sorry." and "I just told you I forgot. I meant to pick it up. I'm really sorry."). Psychologists have taught us that we are by nature uncomfortable with ambiguity, so we revert back to familiar, safe, and comfortable interpretations of reality, even if they are only partial representations of or fully disconnected from reality. What we do, in essence, is reduce cognitive dissonance. Kahneman explains that this kind of System 1 thinking infers and invents causes and intentions, which happens automatically. Kahneman also writes that we are hardwired to do so—even infants are equipped for the perception of causality. This system that suppresses doubt and exaggerates coherence is highly effective for fast assumptions, but it also means that we end up seeing a world that is vastly more coherent than the world actually is. System 1 thinking is like a sense-making (or meaning-making) organ in our heads, and we tend to see things that are emotionally and associatively coherent.

While System 1 thinking is essential in helping us make quick decisions, Kahneman warns that it cannot go unchecked (at least not without a cost). He explains that System 1 thinking takes whatever information is available and makes the best possible story out of the information currently available but tells us little about information we don't have. Without the full picture, individuals jump to conclusions. Kahneman therefore calls System 1 a machine for jumping to conclusions, which creates overconfidence. So it turns out that the confidence individuals have in their beliefs is not a measure of the quality of evidence, but rather of the coherence of the story that the mind has managed to construct. Quite often, one can construct good stories out of little evidence. Kahneman warns us that as humans, we tend to have great belief and great faith in stories that often are based on little evidence.

System 2 Thinking: Controlled, Deliberate, Effortful, Usually Conscious

Thus far, we have emphasized the potential flaws associated with automatic (System 1) thinking. However, System 1 thinking is not nonmentalizing per se. Consider the following scenarios.

You wake up in the middle of the night from a noise downstairs.

As you tiptoe into the living room, you see that the window has been broken and a stranger is busy rummaging through your drawers. When the stranger turns around toward you, you notice that he is carrying a knife. In this scenario, while you do not know this for certain, it is in your best interest to assume that the man is a burglar; that his intention is to steal from you; and that if you were to stand in his way, you might get hurt. You will make these assumptions in a split second, without thinking, which will result in behavior such as running upstairs, locking your bedroom door, and calling an emergency number. Put differently, you will be engaging in System 1 thinking. In this case, acting upon your intuition is not a flaw—it has real survival value.

Let's consider another situation: love! Passionate love, rather like fear, can scramble our capacity to hold an idea as a mental representation and lead us, gloriously in most instances, to know that the object of our affections is without blemish, untainted by the many minor (even occasionally major) flaws that—when we are calmly reflecting on humanity as a whole—we can happily accept make up a part of the human condition. So, when a family member or friend tentatively questions his repeatedly turning up late to special occasions, or his making of cutting asides about someone else's dress sense, this is more likely to backfire on the family members ("You're so unsympathetic!" or "You're jealous!") than to stimulate curiosity on our own part about our beloved.

Clearly, unreflective, uncontrolled, and unconscious mentalizing is important to experience the immediacy of emotions that keep us safe (fight-or-flight), give us joy, and help us procreate (love!). Over a candlelit dinner, as a joyful tear tracks down your lover's cheek, you don't want to sit there thinking too hard about the romance of it all; you want to be right there in the moment, knowing the rest of the world can wait. Automatic mentalizing is therefore not by nature nonmentalizing, but can be if it does not benefit the interaction or shared goals of the interaction partners. Here, we would like to emphasize that mentalizing, although it is something that occurs in a mind, is profoundly about social connection, about the threads that bind humans in coherent (or less than coherent) networks of relationship. Therefore, System 1 thinking, if it does not benefit the partnership, cannot go unchecked indefinitely. Certain situations will require a more controlled, deliberate, effortful, and reflective way of

thinking. This is what we refer to as System 2 thinking. We engage in this type of thinking when we are learning a new task or when we are actively trying to figure out something. To illustrate, let's rewind and redo the wife and husband scenario we discussed earlier (see Box 2.1b).

Box 2.1b. System 2 Thinking

WIFE: My darling, did you remember to pick up the dry cleaning?

HUSBAND: Oh no. I forgot. I'm sorry.

WIFE *(feeling annoyed thinking that he did not really want to do it in the first place)*: Oh no! I need the black dress for tonight's work function. I'll make a plan . . . but listen, can I talk to you about a broader issue this relates to?

HUSBAND: Sure. What's up?

WIFE *(remembering the last time her husband forgot to pick up one of the children from soccer practice)*: I know I might be completely off base here, but when you forget to do something like pick up the dry cleaning after we agreed you'd do it, it makes me feel that I and our family are not a priority. It might just be insecurity on my part, but our relationship is important to me and I want to think about this with you.

In the scenario in Box 2.1b, the wife is utilizing System 2 thinking: She actively reflects on her feelings of annoyance, shares her concerns in uncertain terms, and then asks for her husband's perspective. This is an example of System 2 thinking because she is not reacting from her gut (reflexively) but rather reflectively. She is actively slowing down herself and the interaction in order to ensure an optimal outcome for the interaction. Here again we assume that it is her ultimate goal to have an intimate, loving, and supportive relationship with her husband.

Mentalizing is about social connection.

When we engage System 2 mentalizing, we are consciously and actively curious and inquiring about the content of our own or another's mind. We don't make assumptions about what another person is thinking or feeling or why another person acted the way he or she did. Instead, we give ourselves a moment to gather our thoughts, to

contemplate how we really feel; what our thoughts really are; how they might connect to our past and future selves; and, importantly, how our interpretation of another's mind might be influenced or biased by our own thinking. When we mentalize, we are actively trying to determine the meaning behind a particular utterance or behavior. Why did someone say that? Why did someone do that? Therefore, we are assuming that the utterance or behavior was made with intention to communicate; that there is a cause behind the action, facial expression, or tone. Sometimes, an utterance or behavior by someone might be random. By maintaining an open-minded Mentalizing Stance we explore whether there was meaning behind the utterance or behavior without assuming what was intended. Mentalizing therefore promotes uncertainty, curiosity, and humility—it is a not-knowing stance that seeks clarification. Because "it's all in the mind," we give ourselves the space to change our minds and others the space to change their minds. Together, we can reflect on what made us change our minds and discuss the implications of changing our minds. In essence, we develop a shared understanding of what is happening between ourselves and others. We are thinking together. Here, we want to underscore that this takes time. Mentalizing is not done fast (unless you're in System 1 mode and running up the stairs to call 911). We will return again and again to this idea of slowing things down; and it's really System 2 that allows us to put on the brakes on an interaction by deliberately, effortfully, and consciously reflecting on the interaction.

To summarize, System 1 thinking involves implicit-automatic mentalizing and refers to a fast, reflexive (not reflective) process that requires little consciousness or effort, while explicit-controlled mentalizing involves more conscious, deliberate, serial reflective processes. For most of us, automatic-implicit mentalizing is our default setting as we do not go through life constantly, explicitly, and intentionally reflecting on the minds of others or our own minds. However, our mentalization becomes more controlled when another's (or our own) behavior no longer makes sense. This creates a bit of arousal in our minds, which (if everything is working as it should) invokes the need to switch to explicit-controlled mentalizing, which is slow and requires us to reflect explicitly on our own minds and the minds of others. The important point is that we are able to activate and use our explicit mentalizing in response to the demands of the

context. When encountering an armed burglar in one's house, it is not the right time for explicit-controlled mentalizing. Under those circumstances we want to be able to rely on implicit and automatic mentalizing that will help us to safety. In contrast, when an employer is accusing an employee of something he has not done, it is in the best interest of the employee to engage in explicit-controlled mentalizing and actively inquire before acting. As you will see throughout this primer, mentalizing is intimately context-dependent. Optimal mentalizing, then, is when the right type of mentalizing is used in the right context. This involves a balance between automatic and controlled mentalizing (e.g.,s unconsciously keeping track of an audience's facial expressions and bodily postures during a presentation, while also asking them explicitly whether you need to pause for questions). Optimal mentalizing may, however, also involve one of the extremes if a situation demands it. The prefrontal cortex is really an attention director that marries a grasp of the context to the most appropriate state of mind with which to address it.

We can use mentalizing in response to the demands of the context.

COGNITIVE VERSUS AFFECTIVE MENTALIZING

The difference between System 1 (implicit-automatic) and System 2 (or explicit-controlled) mentalizing maps to some extent onto the difference between cognitive and affective mentalizing. Mentalizing relies on both cognitive knowledge as well as affective input, but the difference between cognitive and affective mentalizing is grounded in the theoretical work of a developmental psychologist, Alan Leslie (1987). Cognitive mentalizing involves metarepresentations (M-representations) consisting of four parts: (1) an agent, (2) an informational relation that specifies the agent's attitude (pretending, believing, desiring, and so forth), (3) an aspect of reality that grounds the agent's attitude, and (4) the content of the agent's attitude. Therefore, when we actively reflect on someone else's mind, we produce an M-representation such as "I believe you think (that) I'm being mean on purpose". You can see in this statement that we are in the domain of cognition because we are using thinking language. The

overlap with System 2 (explicit-controlled) thinking is clear because in order to engage in metacognition we have to step back from what we are doing and actively, consciously make use of mental state language to denote that we are not talking about reality, but what we think about reality. Table 2.1 presents examples of these metacognitive statements compared with nonrepresentational statements.

The moment we introduce thinking language like the words in bold in Table 2.1, we are engaging in cognitive mentalizing. It is mentalizing, because we introduce uncertainty, tentativeness and curiosity to our statements. We are not stating reality, but our perspective on reality. In essence, we slow down our statements and we slow down the interaction. We are not jumping to conclusions but open up the possibility for our interaction partner to disagree with us or to give us his perspective.

In contrast, affective mentalizing is more feeling based and relies on what Simon Baron-Cohen and colleagues (Baron-Cohen, Golan, Chakrabarti, & Belmonte, 2008) have referred to as the empathizing system. Whereas cognitive mentalizing relies heavily on language, affective mentalizing relies on emotional components of interaction (Klein, 1996; Sharp et al., 2021; Sharp et al., 2020): smiling, touching, synchrony, turn taking, sharing of joy, mutual attention, mutual engagement, containment, eye contact, physical closeness, touch, empathy, and validation. As opposed to cognitive mentalizing, which relies quite a bit on System 2 (explicit-controlled) thinking, affective mentalizing relies more on System 1 thinking (implicit-automatic). It is unconscious and cannot be easily faked. In the therapy room, we think about these components as being present, being in the room, or connecting with a client.

For many people, affective mentalizing does not come naturally, but may be blocked. Consider, for example, someone who has been maltreated. For him, affect is a dangerous thing and utilizing affective components in an interaction may be inhibited for pure reasons of self-preservation. Consider also the novice therapist who struggles to make use of affect in working with his client. He will engage much more comfortably in cognitive mentalizing, where he can make use of his excellent logic and thinking skills. It could be argued that the incredible scale-up of CBT interventions is partly explained by the possibility that CBT offers great safety because a therapist can

TABLE 2.1. Representational and Nonrepresentational Thinking

M-Representations/Metacognitive Thinking	Nonrepresentational Thinking
"I **think** she wants to be friends with me."	"She wants to be friends with me."
"I **wonder** if she would like to be friends with me."	"She would like to be friends with me."
"I **believe** we could be good friends."	"We could be good friends."
"I **thought** he was going to call me last night."	"He was going to call me last night."
"I was **under the impression** that we figured it all out last time we talked."	"We had it all figured out last time we talked."
"She **seems to** be feeling upset."	"She is upset."

utilize CBT skills without the use of affect. Of course, the good CBT therapist makes use of just as much affective mentalizing as an MBT therapist, but adherence to MBT requires both affective and cognitive mentalizing while CBT does not.

Part of what makes affective mentalizing so hard is that it is unconscious (hence the association with System 1 thinking), and an individual becomes aware of it only when he observes himself in a video or if someone gives him feedback on it. In MBT training (as with all psychotherapy training), it is therefore vital to make use of session videos in supervision to enhance affective mentalizing in novice therapists. The optimal mentalizer is one who makes use of affective and cognitive mentalizing in a context-dependent way. When a client is upset, cognitive mentalizing will likely be counterproductive. Equally, when a client is blocking the experience of affect, affective mentalizing may be counterproductive. In later chapters, we will talk more about how the MBT therapist moves between the polarities of cognitive and affective mentalizing.

MENTALIZING BASED ON INTERNAL FEATURES VERSUS MENTALIZING BASED ON EXTERNAL FEATURES

Mentalizing well calls for balancing another set of polarities. Consider the distinction between mentalizing based on the external features of self or others (e.g., their facial expressions; noticing that your palms are sweating) and assumptions about internal features of one's

own mind or another's mind. We have all been in the company of people who have trouble reading the social signals we send them. For instance, imagine a situation in which you are trying to indicate to another person that you would like to wrap up a conversation. You might tap your fingers, look at your watch, and talk in a clipped or hasty tone. Yet, the receiver of your signals remains oblivious to these external social cues until you blurt out, "This is not really a good time to have this conversation." If you do in fact find yourself in the company of such a mind-blind person, it would behoove you to pause and mentalize him based on the internal features of his mind. Why is it that he is not reading your cues? You might then say something like "I can see this is an important topic for you to discuss with me, but at the moment I'm pressed for time. Shall we make an appointment to properly talk about all this?" In this fictive exchange we see how a lack of focus on a person's internal or external features leads to a breakdown in mentalizing, and how a focus on the internal features of someone's behavior, at the right time, might resolve it. Optimal mentalizing is when a balance is achieved by using both internal and external features reflecting a person's mind.

MENTALIZING, GOALS, AND VALUES

The astute reader will have noticed that we have been describing four polarities of mentalizing. We recap them again here in Figure 2.4.

Throughout, we have been talking about how the optimal mentalizer is someone who engages in these dimensions based on the context he is in (recall the home intruder scenario vs. resolving the dry cleaning incident). So context dependency is really important. But there is another set of constructs that are equally important, and those are goals and values. Here, we would like to pause for a moment to discuss in more detail the connections between mentalizing, goals, and values.

In our husband and wife scenario (Boxes 2.1a and 2.1b) you will remember that we assumed the husband and wife shared the goal of having a loving and intimate relationship with one another. When we mentalize, especially when we do so deliberately (System 2 thinking), we engage in this imaginative activity for a goal or a

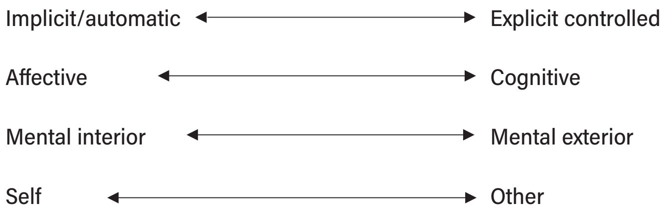


FIGURE 2.4. The mentalizing polarities.

purpose. Our goals typically flow from our values. In the context of interpersonal relationships, for most of us, our goal is to understand others and ourselves, to get on with people and improve the quality of our relationships. Where do these goals come from? The simple answer is that they come from some identifiable or articulated value like "I value being close to my husband." As we will discuss in later chapters, it is important in MBT to reflect with a client on his values and goals. Thus, when mentalizing, we are not only concerned with understanding and explaining the intentions of others, but we are, crucially, busy with understanding and owning our own intentions. What is it that I want from my relationships with my spouse, my children, my colleagues, my clients, and my students? Who do I want to be in this world? What sort of partner, employee, colleague, friend, parent, or therapist do I want to be? Once we know what we value, we can formulate our goals. If I value being cooperative, then my goal will be to repair a rupture in that relationship or to mend a falling out. I will therefore intend (be motivated) to stop and think, not only what I want to communicate to my interaction partner, but what I want my partner to hear or understand. In both versions of Box 2.1 we saw the wife failing to remember her values and goals in her relationship with her husband, and her expressing to him what she wanted to communicate ("I'm angry at you. You forgot to pick up the dry cleaning just like you always forget other important things.") and not what she wanted him to hear ("When you forget to pick up the dry cleaning after we agreed you'd do it, it makes me feel that I or our family are not a priority. Our relationship is important to me so I want to work this out so that we can have a loving and intimate relationship."). In clinical practice, we have found this to be one of

the most useful tools for clients (and therapists!)—stopping to reflect on what they want the other person to hear rather than what they want to say. For all of us when we are stressed, but particularly for those individuals who may suffer from personality disorders, there is often a disconnect between what our intentions are, what we communicate, and what is understood or heard at the other end. When mentalizing well, goals and values line up.

In summary, an optimal mentalizer looks like this:

- He is relaxed and flexible, not stuck in one point of view.
- He can be playful, with humor that engages rather than hurting or distancing.
- He can solve problems by give-and-take between his own and others' perspectives.
- He describes his own experience, rather than defining other people's experience or intentions.
- He conveys ownership of his behavior rather than a sense that it happens to him.
- He is curious about other people's perspectives and expects to have his own views extended by those of others
- His mentalizing is context-dependent: he can move flexibly between automatic-implicit mentalizing and controlled-explicit mentalizing as the situation demands.

Below, in Box 2.2, we provide two examples of a typical everyday experience between a mother and a daughter. See if you can spot the mentalizing versus the nonmentalizing interaction (adapted from Sharp et al., 2020).

In the mentalizing example (the second example in Box 2.2) the interaction took probably twice as long as the interaction in the nonmentalizing example. If you commit to mentalizing, you commit to slowing down your interactions with others. When working with parents and caregivers, we remind them that the minutes they lose in mentalizing their children are gained in hours, months, and sometimes years it takes to undo the consequences of nonmentalizing. As we will see in Chapter 3, mentalizing fosters self-regulation and bonding, which in turn equips a developing child to cope with the inevitable stressors of life.

Box 2.2. A Typical Late Afternoon: Things Go Not So Well

Example 1

A mother, arriving tired at home after a full day of work, finds her 8-year-old daughter has not completed her homework as previously agreed upon. The mother puts down her bag, sighs, and looks at her daughter, who is sitting in front of the television watching a favorite show. "What?" says her daughter. Mom responds by saying, "You know what." Her daughter appears baffled. Mom sighs again and reminds her daughter in a somewhat exasperated tone that they agreed at school drop-off that the 8-year old would complete her homework at after-school care. Her daughter explains that she forgot, and Mom says, "Well, that's not good enough. Go sit down now and do your homework while I start dinner. No buts! Now! Go sit down." The daughter becomes distressed and says that she wants to finish her show. Mom becomes more exasperated and says, "I don't want to be saddled with your homework after dinner. Do it now! Or no more television for you for the rest of the week." By now, the daughter is crying and runs off to her room.

Example 2

A mother, arriving tired at home after a full day of work, finds her 8-year daughter has not completed her homework as previously agreed upon. She finds her daughter sitting on the couch watching a favorite TV show. She quietly sits down next to her daughter, takes the remote control, and says: "Sarah, can I pause your show for a moment? I have something important to talk to you about." Her daughter says, "Yes" and turns to her mom. Her mom, making eye contact, says, "I can see you are busy watching your favorite show, but I realize that your homework is still not done, and we will need time to go over it together. What about we look at it together to see what still needs to be done, and then we can decide how to fit it all in around dinner?" Sarah grudgingly agrees (partly because her show has not been completely switched off and she is agreeing to come up with a plan to get the homework done but not necessarily have to do it right now). "Ah!" says her mom. "Look at this! Your teacher has asked you to do more exercises in fractions. What do you think about that?" Sarah then says that it's easy to do that. Her mom says, "Will you show me how you do it?" By now, Sarah is somewhat excited about showing her mom how fractions work, and she begins to work on her homework. After the first problem is completed her mom says, "Excellent work—I like how you first think through the problem

and then write down your answer." Sarah smiles and starts on the next problem. Her mom then says, "It's close to dinnertime, do you want to continue on with the fractions while I make dinner and then watch your show after dinner? Or do you want to wait till after dinner to do your homework?" Because Sarah is excited by the positive feedback and the thought of completing her homework, she elects to go on with her homework while her mom cooks dinner.

Before moving on to Chapter 3, we would like to emphasize some additional points about the Mentalizing Stance. The first is that there is mostly a rapid flowing back and forth between mentalizing and nonmentalizing states of mind, even changing from the beginning to the end of a single sentence (consider the mother talking to her procrastinating daughter. Fostering an awareness of the rapid shifting in all of our minds between some mentalizing, some certainty (psychic equivalence), some mentalizing, some action (teleology), some mentalizing, some waffle (pretend mode), and back again, is helpful; this awareness engenders a less concrete understanding of minds (that minds are either good or bad depending on whether they are mentalizing or not). In truth we all move in and out of mentalizing, and that is mostly just fine. In the next chapter, we delve more deeply into the nonmentalizing modes (teleological, pretend, and psychic equivalence).

CHAPTER SUMMARY

This chapter was concerned with introducing you to the concept of mentalizing. It is critical that you have a good understanding of this multidimensional construct because understanding it means that you can employ it in your therapeutic work. To this end, we introduced you to the four mentalizing polarities (self vs. other; implicit-automatic vs. explicit-controlled; affective vs. cognitive; and internal vs. external). We emphasized that good mentalizing has to do with maintaining a balance between polarities that is context-appropriate. As such, mentalizing at any extreme polarity may be justified if the context calls for it. In most cases, we strive for a balance between poles in our mentalizing, because this implies flexibility of thought—that is, being able to view things from multiple perspectives to increase

our understanding of ourselves and others. In introducing the concept of mentalizing, we also emphasized the importance of goals and values in mentalizing. Beyond individual differences in mentalizing capacities (which may be determined by genes or gender), wanting to mentalize our partners is a prerequisite for good mentalizing. You should, by now, have a good understanding of what we mean when we use the word mentalizing, and what optimal mentalizing looks like. We are now ready for Chapter 3, in which we discuss how mentalizing develops.

CHAPTER 3

How Does Mentalizing Develop?

Fonagy and colleagues' mentalization-based approach, like most psychodynamic approaches to psychotherapy, is rooted in early attachment relationships with caregivers, and is therefore fundamentally **developmental** in nature. This means we view every individual at any given moment as a complex product of her genetic endowment in interaction with early environmental (attachment) influences, and how those early forces interact, in turn, with more proximal (current) circumstances or stressors. The mentalization-based developmental model is rigorously grounded in empirical research (see Fonagy & Luyten, 2009, 2016; Fonagy & Sharp. 2008; Kim, 2015; Sharp & Kalpakci, 2015, for recent reviews). What we present below is a distilled version of this empirical research in order to provide an accessible understanding of the model for the development of typical mentalizing capacity.

Mentalization-based treatment is fundamentally developmental.

NORMATIVE TIMELINE FOR THE DEVELOPMENT OF MENTALIZING: THE PREMENTALIZING MODES

Table 3.1 maps out the normative timeline for the development of mentalizing as described in the developmental literature.

TABLE 3.1. Normative Development of Mentalizing

Developmental Period	Mentalizing Capacity
Infancy (0–6 months)	• Body awareness. • Some awareness of caregiver's attention. • Detects, responds to, and directs other's attention to her face and body. • Some awareness that she is separate from the world. Affectively rich communicative exchanges with caregiver.
Infancy (6–12 months)	• Physical self-recognition. • Begin to move from self-orientation to social orientation. • Begins to understand that actions have goals. • Development of **teleological thinking:** the use of observable physical reality to make inferences about goal-directed nature of actions (e.g., sees bottle of milk → drink bottle of milk). • Beginning to understand cause and effect. • Social referencing: seeks out the caregiver's emotional reactions to gauge her own affective reactions. For instance, a baby becomes fascinated with the way a branch is moving in the sunlight. The baby points at the branch and looks at Mother, waiting to see that her eyes focus on the branch. When they do, that is satisfaction enough that "she gets it!"
Toddlerhood (2–3 years)	• Understands that actions emanate from unobservable mental states but cannot actively reflect on mental states of others. • Implicit-automatic (System 1) mentalizing capacity (e.g., sister cries → comforts sister). • Can recognize basic emotion/facial expressions. • The idea of "me" emerges through pronoun use. • Autobiographical memory emerges. • Pretend play develops, which is the first practice in decoupling the mind from reality, but pretend games feel very real and child can get lost in magical thinking. • What is in my mind is real: **psychic equivalence**. • Begins to experience social emotions (shame, pride, embarrassment).
Early childhood (4–5 years)	• Monumental achievement in passing the false-belief task. • Can now decouple the mind from reality. • Achieve rudimentary explicit-controlled (System 2) mentalizing capacity: can verbally reason and interpret behavior and intentions behind behavior. • The capacity to deceive develops. • Begins making causal references to mental states. • Significant increase in mental state language. • Elaborated use of the pronouns *I, me, myself.*

(*continued*)

TABLE 3.1. (*continued*)

Developmental Period	Mentalizing Capacity
Middle childhood (6–11 years)	• Higher-order mentalizing develops (“he thinks she thinks that . . . ”). • Begins to understand and differentiate between lies, jokes, irony, sarcasm. • Can carefully construct lies without leaking information that may lead to suspicion. • Significant increases in perspective-taking skills. • Understands social emotions (shame, pride, embarrassment). • Has the capacity for social exclusion, so creates “in-groups” and “out-groups” and may exclude or include others in play. • Understands personality traits and uses them to explain behavior. • Capacity for self-narrative begins to develop but is still rather concrete and unintegrated. • While mentalizing is in place, it is influenced by moral development and internalization of societal values—how one should think and feel. Mentalizing therefore lacks some authenticity and **pretend mode** is apparent in recounting of events and self narrative. • Capacity for social comparison emerges. • Self-evaluation largely positively skewed during early period of middle childhood and gradually becomes more realistic.
Adolescence (12–17 years)	• Social reorientation takes place: from parents to peers and romantic partners. • Identity consolidation begins. Identity defined as intrapersonal and interpersonal continuity; making sense/meaning from self-concept. • Cognitive development facilitates integration of self-representations and multiple self-hypotheses. • Autonomous self begins to emerge. • Cognitive development impedes control over emotions. Context sensitivity (shame, embarrassment, anxiety about social standing in relation to newly understood social rules) easily overwhelms cognitive mentalizing. • Shared reflection with peers. • Mature perspective-taking abilities, but self-consciousness and imaginary audience. • Stepping outside the social dyad to view self as a social object that is observed by others. • Abstract representations of self. • As control over emotions increases, greater sense of agency emerges.

Infancy (0–6 months)

Mentalizing capacity begins in the body, albeit in a reflexive, automatic way. A baby is endowed with the capacity to reflexively (automatically) know whether she is cold, hot, wet, dirty, or hurt. Because the baby cannot mentalize her bodily experiences with any explicit, cognitive reflective capacity, she is heavily reliant on her caregivers to help her mentalize her subjective experiences, which, as we said, mostly center on her bodily experiences. Her first job is to communicate this rudimentary subjective knowledge to her caregiver by crying or vocalizing. The following vignette illustrates how a mother might be responding to her crying baby:

> "Oh oh . . . hang on, little one . . . you need me to pick you up . . . let's see what's going on . . . let me peek into your diaper. . . . Oh, I see! You made a pee-pee. I think you're feeling all wet and uncomfortable. Let mommy help you . . . hang on . . . I'm putting you on your back and unzipping your onesie. Let mommy take off your diaper. There—there. Ah, now we get a wipe and clean you up nicely. Almost done. Just some paste and then I can wrap you back up. You'll feel nice and warm again."

We can imagine that during this interaction the mother is looking into her baby's eyes. She might be smiling gently, and her voice is soft and reassuring while she talks to her baby. The mother is busy *translating* or *mediating* the baby's subjective experience through the use of language, while at the same time making use of affect (emotions) to connect with her baby. In essence, the mother is mentalizing the baby's mind, even though the baby's mind is reflexively responding to her own bodily needs. The crucial point is that the mother is responding to the baby *as if* the baby has a mind (albeit a reflexive mind); and she uses affect and language to give meaning to the baby's subjective experiences—however rudimentary those experiences are from the adult's perspective (being hot, cold, hungry, hurt, wet or dirty).

The intensity with which the baby responds to her own discomfort or distress is determined by her **temperament**. Temperament is defined as the early-appearing variation in reaction and emotional reactivity and is first and foremost biologically (genetically) based.

Research has shown that babies with a difficult temperament will experience more distress in response to their bodily states—being wet, cold, warm, dirty, or hurt. They will express that intensity more loudly and for longer periods of time compared to their easy counterparts. They will be harder to soothe and will be more irregular and unpredictable in their bodily functions and patterns. Caregivers of difficult, temperament babies need *special skills* to help mediate their babies' subjective experience of their bodies.

Infancy (6–12 months)

During the second six months of life, the baby begins to move beyond her body and takes the first step to becoming social. This is a delightful time for parents, and the first social smile is an unforgettable moment of joy for most parents. The baby moves from self-orientation to social orientation and is able to direct her attention to her caregiver in more goal-directed ways. She is also able to direct her caregiver's attention to herself in a more goal-directed, less reflexive way, and she begins to make use of social referencing (that is, seeking out the caregiver's emotional reactions to gauge her own affective reactions). The caregiver continues to *connect the dots* for the baby by linking certain events or objects with one another. Below is another example of how an interaction may take place now that the baby is in the second 6 months of her life:

> "Good morning, little one! I heard you crying and came right over. How are you doing? Let me pick you up . . . oh, you feel nice and warm . . . are you hungry? Let's get your bottle ready . . . yes . . . it's breakfast time . . . see, it's light outside . . . come, let me hold you like this and we go get your bottle."

Here, we see how the baby is beginning to learn the connection between feeling hungry, getting her bottle, waking up, and breakfast time. She is beginning to understand cause and effect, albeit in a rudimentary way. This is the beginning of **teleological thinking** (a prementalizing mode)—a term we will return to many times throughout this book. Teleological thinking is defined as the use of observable physical reality to make inferences about the goal-directed nature of actions—we can think of teleological thinking as *concrete thinking*.

The use of observable physical reality to make inferences about the goal-directed nature of actions is based on a basic behavioral principle of stimulus and response. When I see my bottle, I'm going to get milk. When it is dark outside, it is sleep time. If I pee-pee in the potty, I'll get a star for my star chart. Even Donald Winnicott's *transitional objects*—the lovey blanket or soft toy that is used to repetitively tickle noses or to cuddle with—are teleological in that they are concrete, observable representations of attachment needs. Teleological thinking is regularly used throughout childhood to shape behavior based on stimulus–response pairings, and babies and small children (and our pets!) respond to these behavioral interventions early on.

Teleological thinking also shapes some of the earliest interactional patterns between infant and caregiver, shaping or forming the building blocks of mentalizing. The infant from early on can notice and respond to eye movements in other faces, and an early interactional pattern that many parents will recognize is when the baby learns to point at something that has caught her interest—the way the light is moving in some leaves overhead, for instance. The baby will point at the leaves that are so captivating, then pointedly look at Mom, then back at the leaves. Then checking back, the baby is satisfied to see Mom's eyes have moved to look for what is so special up there in the leaves. It's not sophisticated mentalizing, but at this tender age it will do: "I've seen this wondrous thing, but Mom hasn't got it yet. If Mom's eyes point at what I'm enjoying, then it means she is with me": the fact that Mom may still be wondering where she left the blanket, or when the car needs collecting from the repair shop, is neither here nor there—for the baby, if her eyes are up there with mine, we are connected, and all is good. It's the solution of a worry ("Perhaps I am all alone with this stimulating leafy sight!") by a simple physical outcome (Mom's eyes pointing at said foliage), but in it there are the earliest signs of interest in another mind.

Toddlerhood (2–3 years)

Whereas mental states are very much embedded in the body as well as physical objects during infancy, 2- to 3-year-old children begin to understand that actions may emanate from unobservable mental states. A 3-year-old may be saying something like "My sister is crying. She is sad." Thus, she is able to recognize basic emotions and

facial expressions. However, at this age, toddlers are not yet able to actively reflect on the mental states of others. The toddler is therefore still engaged mostly in automatic, implicit mentalizing without the option of explicit reflective mentalizing. But as the social circle of the toddler widens, the caregiver begins to play an increasingly important role in facilitating more explicit-controlled mentalizing. For instance, if a sibling is crying, a mother might say, "Oh no! Sissie is crying. What do you think might be going on? Should we ask her?" In other words, the caregiver is using language to expand mentalizing capacity not only in terms of self function (as in infancy), but also in terms of interpersonal function. The spurt in language development that occurs in toddlerhood is also associated with the emergence of *me* through pronoun use and the beginnings of an autobiographical memory.

An important milestone for mentalizing development during the toddler years is the development of pretend play, the first practice in decoupling the mind from reality, which, as discussed in Chapter 1, forms a key complement of the capacity to mentalize. However, pretend play still feels real for a child. Jean Piaget described this as "magical thinking"—the belief that one's thoughts, by themselves, can bring about effects in the world or that thinking something corresponds with doing it (e.g., "The soap slipped down the drain, so I can, too"). It is magical thinking that often complicates potty training—for instance, believing that it is possible to be flushed down the toilet with a poo-poo which came out of one's own body. It is magical thinking that causes fear of monsters in the closet, and it is magical thinking that also provides endless joy for toddlers dressing up as princesses or pirates. Once dressed, a 3-year-old becomes Anna or Elsa or Beauty or Peter Pan. In short, for the young child *what is in my mind is real*—and in mentalization-based terms, we call this **psychic equivalence** (another prementalizing mode we will return to again later).

Early Childhood (4–5 years)

Around age 4, we witness the monumental achievement of passing the false-belief task we referred to in Chapter 2. Children can now officially mind-read! That is, they can decouple the mind from reality and they can verbally reason and interpret behavior and intentions

behind behavior. In other words, we see for the first time the capacity for explicit-controlled mentalizing. With this, the capacity to deceive develops, although it is not very sophisticated, and most parents can see right through it.

During this period, there is also a marked increase in the use of mental state language. The parent's role continues to be that of mediator of subjective experience. To bring this role into sharper focus we can imagine the difference between a child playing with a stick in the water by herself versus playing with a stick in the water with an adult who engages the child in conversation about what she may find in the puddle, things that may be lurking under the rocks, and how the tide may be pushing the seawater in an out of the pool. We can equally imagine the difference between a small child crying alone after having his feelings hurt by a friend; vs. a small child crying in the arms of his dad feeling the warmth and strength of his father as he sobs. Put differently, caregivers continue to mediate the subjective experience of children to help create meaning for them. In this respect, Pnina Klein (1996), a developmental psychologist, wrote about the caregiver's role in creating "mediated learning experiences" for children. Elsewhere (Sharp et al., 2020; Sharp & Marais, 2022) we have described that a mediated learning experience begins with interactions on a preverbal level and is not related specifically to a modality, language, or content and is, therefore, a universal phenomenon. As a child matures, mediated learning experiences become verbal in addition to nonverbal and enable the child to benefit from experiences that he or she has not perceived directly, but can only perceive because an adult mediates them. The transmission of the past is made possible this way; and the awareness of the past and mediated anticipation of the future enable the child to expand his or her understanding of time and space. A child who receives mediated learning experiences develops a need for more mediation, that is, a need for events or objects to have meaning, a need to search for relations beyond the information provided by the senses at any given moment. In sum, mediated learning experiences enable further change of the individual through direct exposure to stimuli and allow a child to acquire basic structures that prepare her for future learning. Adult–child interactions can be considered as mediated learning experiences if they are intentional and reciprocal, if they transcend the satisfaction of an immediate need, and if they mediate meaning. We will again return to the idea of learning later

in this book, as learning forms an essential part of the mentalization-based approach to understanding psychological functioning. Learning from each other, passing on information, and creating the shared systems of meaning that make up culture is one of the key aspects that distinguishes humans from other mammals. Later, we will show how mentalizing acts as the key to an evolved *gating system* in the human mind, one that helps us in the crucial task of *deciding* whose minds we should open up our own to, and learn from, and to whom we keep that gate tight shut so that their influence on our mind is minimal.

Middle Childhood (6–11 years)

With basic ToM or mentalizing capacity in place, the middle childhood years see the development of higher-order mentalizing capacity. This includes what Happé (1994) referred to as second-order ToM ("He thinks she thinks that"), as well as lies, jokes, irony, and sarcasm. Parents endure hours of riddles as their 10-year-olds rejoice in the world of mind tricks and games. There is a sharp increase in perspective-taking skills such that the preadolescent is able to understand complex social interactions. The price these sophisticated mind-readers pay is, however, the sharp increase in social emotions (shame, pride, embarrassment, and so forth) and the risk of social exclusion, all of which develop with the increasing capacity for social comparison. We also begin to see a gender difference widen in social intelligence. Research shows that compared to boys, girls are already more advanced in mentalizing capacity at birth, and that this gap begins to widen in preadolescence and only normalizes again in adulthood when men catch up to women in social intelligence, albeit always lagging a little behind (Baron-Cohen, 2004).

An important development in middle childhood is the awareness that people have personalities. Children begin to use dispositional traits for the first time to explain others' behaviors and actions. They begin to develop a sense of their own personalities, albeit concrete. For instance, asked the question, "Can you describe yourself?" an 8-year-old may say, "I run really fast." Views on the self are also unintegrated and inconsistent. For instance, a 10-year-old may say she hates math on Monday, only to recant on Tuesday. Children at this stage show a positively skewed (unbalanced) self-concept and are

concerned with morality and how things *should be* and how things *should be done*. Pretend mode (the third prementalizing mode we will refer to many times throughout this book) characterizes this tendency to act in an *as-if* fashion based on expected rules or scripts rather than what naturally fits with the person or situation. Middle childhood is not the first time that pretend mode is detected in children. The toddler shows pretend mode, for instance, in her apparent competence when she says she is “a big girl” for using the potty. But it is during middle childhood when we see the lack of authenticity most clearly displayed given the strong push for what Erikson (1950) named “industry” (vs. inferiority). Erikson pointed out that the child at this stage of development feels the need to win approval by demonstrating specific competencies that are valued by society. Often, the enactment of a particular competence, even if it does not feel real, helps the preadolescent to avoid inferiority as she figures out her true talents and skills.

Adolescence (12–17 years)

Adolescence is another watershed period for the development of mentalizing capacity because it is during this stage that *adultlike mentalizing of the self* begins in earnest. Research has shown that during adolescence, two related and important changes occur, namely social reorientation and accompanying brain changes in the frontolimbic system (Guyer, Silk, & Nelson, 2016; Nelson, Leibenluft, McClure, & Pine, 2005; Sawyer, Azzopardi, Wickremarathne, & Patton, 2018). In tandem, these two processes facilitate increased perspective taking and mentalizing others, which in turn spawn tremendous growth in the capacity to mentalize the self. Let’s unpack this complicated process a bit (see Sharp, Vanwoerden, & Wall, 2018, and Sharp & Wall, 2017, for a further discussion of this topic).

For some time we have known that adolescence is the developmental period during which children expand their attachment and social circles to go beyond parents to include peers and romantic partners. In this vein, the adolescent’s primary influences shift from vertical (parents, teachers, and other key adults) to horizontal (their position in the social milieu). Middle and high school

In adolescence, adultlike mentalizing emerges.

generally bring with them a new social environment, which is for most adolescents a high-stakes environment on account of its potential for hosting episodes of social shame in ways that the primary (parental) environment simply did not. In that sense there is a strong sense of *life getting serious,* at least in terms of social standing. In addition, teachers and parents begin to hold more stringent expectations for adolescents. These environmental changes set the stage for new dimensions of social comparison (e.g., academics, extracurricular activities, appearance). Additionally, consequences of academic achievement gain greater weight with adolescents starting to consider possible future selves, such as college and potential occupations. At the same time, peer relations stabilize into intense and serious friendships while teens begin to navigate and balance these friendships with emerging romantic attachment relationships. This social reorientation and expansion coincide with expanded cognitive skills, specifically with regard to increased perspective-taking skills, as well as increases in self-consciousness and concern about the appraisal of others. However, there remains an underdeveloped prefrontal control over these new capacities. The end result in some cases is extreme or ineffectively applied use of these new cognitive capacities, such as overthinking or overreacting, which cannot be held in check by the as yet still weak inhibitory power of the prefrontal cortex.

The joint result of these two developments (social reorientation and uneven cognitive development) are, on the one hand, the capacity for shared reflection with peers such that one's personal goals become integrated with the goals of close others; and on the other hand, the development of an *imaginary audience,* referring to the perception that "others are as preoccupied with (and interested in) my behavior as I am," missing out on the fact that it is much more likely they are as preoccupied with *their* behavior, as I am with mine.

It has been suggested that the imaginary audience phenomenon is a function of the separation–individuation process of adolescence. Constructing an imaginary audience creates a sense of closeness and importance among peers as adolescents renegotiate relationships with parents, which reflects the expansion of intimacy and close relationships beyond the family system to peers and potential romantic partners. For the first time, adolescents are able to step outside the (parent–child, teacher–child) dyad and view themselves as social objects (from the outside in). This is a complex process because they have to

integrate multiple self-hypotheses with feedback from peers, parents, teachers, and the wider social environment. They have to reflect on themselves in relation to others to decide which perspectives to internalize as defining features of their identity. Moreover, whereas preadolescents' unreflective and positively biased self-acceptance buffered them from potential negative self-images, adolescents begin to form more realistic views based on multiple perspectives on themselves. Whereas cognitive constraints on self-reflection enabled preadolescent children to compartmentalize different aspects of the self, adolescents no longer have that luxury and have to begin the hard labor of forming a consolidated identity. This has the potential of leading to doubt and uncertainty as adolescents consider multiple perspectives and opinions. Self-representations may become removed from concrete, behavioral evidence and therefore may be inaccurate. This means that adolescence is for some individuals a time of increased intrapersonal conflict, confusion, distress, and potential instability in self-representation. Conversely, it is this potential for uncertainty (however vulnerable it may feel) that opens up the gateway to mature mentalizing capacity. Adolescence is therefore the quintessential double-edged sword: with maturation of social-cognitive capacity, vulnerability for derailment increases—therefore it requires quite a bit of scaffolding from the social environment to help adolescents get over this important developmental hump.

It is not until late adolescence that an adolescent is able to integrate various self-representations to resolve apparent contradictions. By then, the ability to develop narratives that explain how chronological events in her life are linked comes online (this is referred to as **causal coherence**). Additionally, by mid- to late adolescence, individuals are able to identify overarching themes, values, or principles that integrate different events in their life, called **thematic coherence**. Both causal and thematic coherence becomes possible thanks to the adolescent's newly acquired ability for higher-order abstraction, which is used to meaningfully integrate what previously seem contradictions in her self-representations and allows for the individual's identity to consolidate. Dan McAdams (2015) talks about the "binding of personality" to capture the coming together of disparate aspects of personality functioning into a coherent whole. We have referred to this as the developmental period where self and interpersonal functioning (recall LPF or Criterion A, which we discussed in Chapter 1) bind

into a unidimensional severity criterion (Sharp & Wall, 2021). This achievement is extraordinary. For instance, a young person may be able to recognize that she talks rebellion with their peers but acts as a dutiful loving grandchild with her elderly grandmother, and instead of being burdened by feeling like a hypocrite or fake, she can construct this as an example of her kindness and adaptation to the fact that Grandma is unlikely to change at her age. Indeed, by late adolescence, individuals start to normalize potential contradictions in self-representations, which serves to reduce internal conflict. As adolescents move into young adulthood, they gain a greater sense of **agency** as they take steps to become their future selves. Of course, for some adolescents this process is not as smooth as for others. We will return to how personality development (binding) may go awry in Chapter 4.

THE ATTACHMENT ROOTS OF THE CAPACITY TO MENTALIZE

Throughout the discussion on the normative developmental progression of mentalizing capacity, we have mentioned the role of the caregiver in this progression. In this section, we further expand on that role.

It is universally accepted that sensitive early caregiving leads to positive cognitive and socioemotional outcomes for children. John Bowlby's (1973, 1980) attachment theory suggests that the caregiver's capacity to sensitively respond to a child's physical and emotional needs is important for the development of secure internal working models of the self and others. Internal working models are *representations* of attachment relationships and become the blueprint (or cognitive schema) that individuals use to understand and manage their attachment relationships as they mature through childhood, adolescence, and adulthood. A secure attachment representation means that an individual trusts that an attachment figure (e.g., a parent, husband, wife, best friend) is available to them and will meet their emotional and physical needs. In contrast, an insecure attachment representation is characterized by mistrust and expresses itself by either dismissing the attachment figure (or the possibility of needing them), or being preoccupied with whether the attachment figure actually cares about them.

Research over the last 60 years has shown that secure attachment

is associated with resilience and positive outcomes in children and adults while insecure attachment is associated with negative outcomes. For instance, a recent meta-analytic study of nearly 6,000 children confirmed that children with a secure attachment in the early years are significantly less likely to develop behavior problems across childhood (Fearon, Bakermans-Kranenburg, van IJzendoorn, Lapsley, & Roisman, 2010). Early security has been associated with lower rates of delinquent behavior and more positive peer interactions in adolescence. In contrast, attachment insecurity has been shown to be associated with suicide-related behaviors, greater use of residential treatment and inpatient admissions, and a range of psychopathology including internalizing and externalizing problems. Research has also clearly documented long-lasting and severe psychological problems as a result of maltreatment across biological and psychological domains, which exemplifies arguably the most toxic disruption of the early caregiving environment (Cicchetti & Toth, 2005).

According to mentalization-based theory, secure attachment is enabled via the mechanism of caregiver mentalizing. In Chapter 2, we introduced the concept of mentalizing, so by now you should have a fairly good understanding of what is meant by it. Parental mentalizing refers to mentalizing specifically within the caregiver–child attachment context. It is defined as both a cognitive process, akin to psychological insight or perspective taking, and an emotional process, that is, the capacity to hold, regulate, and fully experience one's own and the child's emotions in a nondefensive way without becoming overwhelmed or shutting down (Slade, 2005). In the attachment literature, parental mentalization is also referred to as **parental reflective function** (Fonagy, Gergely, Jurist, & Target, 2002) to describe the parent's capacity to reflect upon both her own and/or the child's internal mental experiences within the parent–child relationship as they manifest in parental descriptions of the ongoing, current, and evolving relationship to the child. Parental reflective function can be classified and rated using a standardized coding scheme based on attachment interviews or interviews specifically designed for assessing parental reflective function. If these descriptions of the relationship with the child show (1) an awareness of the nature of mental states, (2) an explicit effort to tease out mental states underlying behavior, and (3) recognition of the developmental aspects of mental states (and mental states in relation to the interviewer), then

the caregiver is rated as high on reflective function/mentalizing. Put differently, if the caregiver's descriptions of the child contain reference to mental states as described above, then the caregiver is treating the child as a psychological agent, that is, someone with a mind. And in acknowledging that the child has a mind, the caregiver is also acknowledging the child's *autonomy* and agency—that she is a person in her own right.

Recall the nonmentalizing homework example discussed in Chapter 2 (see also Sharp et al., 2020). This example demonstrates a caregiver's challenge in mentalizing her child when her own internal resources are low. When internal resources and assets are limited, it is common for caregivers to take *shortcuts,* which potentially disregards the child's agentic self (her autonomy). In that example, the fastest way in which Mom imagines solving the homework problem is by *making* her daughter get up and sit down to do it. In the mentalizing framework, the mother would be described as nonmentalizing and functioning in the *teleological mode,* which we referenced as a prementalizing mode that is normative in small children, and which we will discuss in more detail in Chapter 4. The mother's desire to get the homework done comes from a noble source—she has good intentions! She wants her daughter to do well at school because she knows that a good education will facilitate a bright future. Perhaps Mom did not have similar opportunities growing up and it's hard for her to see her daughter potentially squandering the education that mom never had. The end result of taking the shortcut, however, is that goals are not accomplished (the homework is still not done), her daughter is upset and crying, and Mom feels even more emotionally depleted. Here we see how less sophisticated **prementalizing modes** of thinking are common in we adults too! Sometimes teleology directs us to just the right thing to do (you feed a baby when she is hungry, you change a diaper when it is full, you grab a child if she is falling), but sometimes we switch into it a little faster than is helpful, creating more conflict or misunderstanding than might have been the case if there had been room for some mentalizing beforehand.

As we describe elsewhere (Sharp et al., 2020), the Mentalizing Stance provides the parent with an alternative to the shortcut, the idea being that when a parent is in a Mentalizing Stance, she is able to **slow down** the interaction and move herself and the child to a more reflective, uncertain, curious, and fluid mode. In other words, by keeping

in mind where the child is mentally in the moment, the parent is able to slow down the interaction and treat the child as a psychological agent with thoughts, feelings, needs, and desires different from her own. It is through this kind of parental mentalization that mentalizing capacity, autonomy, and self-regulation are fostered in the child because the child's mind is *minded*. The child whose mind is minded in this way can use the mind of the carer as a kind of mirror—one that is far more informative than a glassy version, in that she receives dynamic information on how she is perceived by another (trusted) mind, not just how the light bounces between her mind and a piece of glass. If you now revisit the mentalizing homework example provided in Chapter 2, you can see the difference in how the mother is minding the child's mind, resulting in self-regulation and positive affect instead of dysregulation and negative affect exemplified in the nonmentalizing example. Importantly, when mentalizing takes place, interaction partners feel *connected* and feel a *sharing of joy*.

Empirical research supports the importance of parental mentalizing for socioemotional development. For instance, in a now-classic study by Fonagy and colleagues (Fonagy, Steele, & Steele, 1991), *prenatal* parental reflective function was shown to be predictive of *subsequent* attachment security of the infant and of the mentalizing capacity (ToM performance) of the same children during the preschool years, and considerably more so than the parent's prenatal attachment style assessed by the Adult Attachment Interview. In another study, we also demonstrated that low maternal accuracy in predicting children's mentalizing responses is associated with ineffective mentalizing in the child (Sharp, Fonagy, & Goodyer, 2006). In this study, we also showed that superior maternal mentalizing is not associated with better child outcomes compared to *good-enough maternal mentalizing*. In other words, parents do not have to be in a Mentalizing Stance all of the time to ensure positive outcomes in their children. A little above average would suffice! In fact, we would argue that breakdown in mentalizing provides the stimulus for the child to practice mentalizing of the other, as well as outstanding opportunities for the parent to practice and model mentalizing with their child. When a parent fails to make sense of her child in a way that is comfortingly contingent to

The parent can slow down the interaction and treat the child as a psychological agent.

the child's experience, it may be just that mild discomfort that stimulates the child into wondering (mentalizing the other): "Why is that? Oh, Mom looks a bit worried about the car/dog/neighbor, perhaps she just didn't notice this time . . . " If we now consider, for instance, the nonmentalizing homework example we provided in Chapter 2, we can see how a breakdown in mentalizing provides a great opportunity for Mom to make a **mentalizing comeback**.

Box 3.1. A Typical Late Afternoon: Mentalizing Comeback

A mother, arriving tired at home after a full day of work, finds her 8-year-old daughter has not completed her homework as previously agreed upon. The mother puts down her bag, sighs, and looks at her daughter, who is sitting in front of the television watching a favorite show. "What?" says her daughter. Mom responds by saying, "You know what." Her daughter appears baffled. Mom sighs again and reminds her daughter in a somewhat exasperated tone that they agreed at school drop-off that the 8-year-old would complete her homework at after-school care. Her daughter explains that she forgot, and Mom says, "Well, that's not good enough. Go sit down now and do your homework while I start dinner. No buts! Now! Go sit down." The daughter becomes distressed and says that she wants to finish her show. Mom becomes more exasperated and says, "I don't want to be saddled with your homework after dinner. Do it now! Or no more television for you for the rest of the week." By now, the daughter is crying and runs off to her room.

Ten minutes later, Mom goes up to her daughter's bedroom, sits next to her, and takes her daughter's hand. "Sweetheart, I want to apologize. When I came in from work I was tired and impatient. I did not notice that you were in the middle of your favorite TV show and I interrupted you. I wanted to get the dinner done and I panicked. I think I came over a bit harsh. Did it feel that way to you?" Her daughter replies, "Yes, Mommy. I got really upset." Mom says: "Yes, I could see that. And I'm sorry. Can we start over? What would have been a better way for me to bring up that the homework was not done?" Daughter replies, "Hmmm, I don't know. Maybe just pause my show first and ask me whether we can talk?" Mom says, "Yes! You're right . . . let's practice that and see where it goes."

The *maternal mind-mindedness* displayed in Box 3.1 was operationalized by Meins and colleagues who demonstrated in a series

of empirical studies (Meins, 1997; Meins, Fernyhough, Fradley, & Tuckey, 2001) an association between secure child attachment and referential tendencies in infant language acquisition, perspective taking during pretend play, and mentalizing capacity as evidenced by passing a ToM task at age 4. In addition, mothers of securely attached children presented their children with information and instructions that were comprehensible and pitched within the child's zone of proximal development. Such mothers also used speech that contained more mental state terms when describing their children. The capacity of the parent to keep the child's mind in mind during interaction is therefore a powerful predictor of attachment, quality of interactions, and the child's own developing mentalizing capacity.

The parent's capacity to keep the child's mind in mind is powerful.

FROM ATTACHMENT TO LEARNING

A central mechanism described in mentalizing theory and research by which the caregiver achieves the Mentalizing Stance with her baby, is referred to as **affect mirroring**. This refers to the attachment figure's ability to respond with *contingent,* **marked** and *ostensive* affective displays of her own experience in response to her infant's subjective experience, which in turn makes possible the child's development of coherent second-order representations of these subjective experience (Fonagy & Luyten, 2016; Kim, 2015). Efrain Bleiberg has often recounted a scenario in which a baby cries profusely, her little face red and all scrunched up. In response, the mother may look into the eyes of her baby and with a slightly cartoonish imitation of a cross face, but speaking in a reassuringly singsong tone of voice, say, "Oh Sara! What's up little one? You're so upset! Come here, let me hold you just a bit." In this example we may say the mother's communication is marked because she demonstrates that she understands the infant's internal state (her upset face and the sense of urgency this conveys), while concurrently signaling that her own upset facial expression concerns *what she thinks might be the case for* the infant, not her own state of mind. She achieves this by modifying (e.g., exaggerating, slowing down) her display of the infant's affect, rendering

it perceptually distinguishable from her expression of her own affect. She is in that sense showing to her baby her best estimation of what she *thinks* is the baby's state of mind, but is also clearly separating her own mental state from that of the baby. And of course, if all is basically going okay, she is doing all this in real time, and with hardly any conscious effort. Her communication can also be described as rich in *ostensive communicative cues* (Csibra & Gergely, 2009) because she makes direct eye contact with the infant, slightly tilting her head toward the baby, speaking with a singsong "motherese" intonation, and calling the infant by name. In fact, the word *ostensive* literally translates as "reaching out" or "pointing." When we, as humans, engage in ostensive cueing, we are signaling to the recipient at the other end of the interaction that we are about to share some important information—that we are about to "teach" the person something. In this example, through her marked, contingent affect mirroring, the mother is communicating to the baby that she recognizes the baby's distress, that it makes Mom feel sad for her, but that Mom is able to help regulate the distress without becoming distressed herself. Mom is showing Sara that she can shoulder Sara's distress and that Sara and Mom are two separate people—with their own respective minds that contain unique subjective perspectives on what is happening. George Gergely has described this process as the mother demonstrating **pedagogical intention** (intention to teach), signaling to the infant that her expression or utterances concerns the infant and what unfolds within the infant, separate from herself. Over time, through regular exposure to this kind of contingently matched affect mirroring that gradually internalizes, the child first develops an awareness of her subjective internal state, which sets the stage for increasing self-awareness, and increasing control of internal states—in other words, self-regulation.

That's what happens when all's going well. Contrast this process with a scenario where Mom is not able to respond in this marked, contingent fashion, but instead starts crying to the same level and intensity as her infant—perhaps out of exhaustion or exasperation. In this scenario, the communication is *not* marked, but instead offers a perfect mirroring of the baby's distress. The mother tragically fails to communicate that she can shoulder the baby's distress. Her mind and the mind of the baby remain undifferentiated, and the baby learns

neither self-regulation, nor individuation. Instead, she learns that her distress (her affect; her mind) has a powerful and negative effect on her mom and that her mind is potentially dangerous. She learns to either not share her subjective experience with her mom (associated with a dismissing attachment style) or to up the ante by increasing the intensity or duration of her protest (associated with a preoccupied attachment style). We will return to how mentalizing development goes awry in Chapter 4.

EPISTEMIC TRUST

In an extension of the mentalization-based theory, Fonagy and colleagues have introduced the construct of epistemic trust (Allison & Fonagy, 2016; Bo, Sharp, Fonagy, & Kongerslev, 2015; Fonagy & Allison, 2014; Fonagy & Luyten, 2016). Epistemic trust is defined as "an individual's willingness to consider communication conveying the knowledge from someone as trustworthy, generalizable and relevant to the self" (Fonagy & Luyten, 2016) or the ability to appraise incoming information from the social world as accurate, reliable, and personally relevant because it holds broad social value rather than simply personal value to its original bearer. Appraising it this way will allow for that information to be incorporated into the learner's existing knowledge domains (Fonagy, Luyten, & Allison, 2015; Sperber et al., 2010). As we have discussed, in secure attachment relationships, parents consistently adopt a Mentalizing Stance toward the child, seeing the child as an intentional psychological agent with a mind and attempting to make sense of the child's behavior as arising from underlying mental states. The caregiver conveys understanding of the child's subjective experience in a way that is accurate (i.e., personally relevant) and marked as the parent's *representation* of the child's mental state. Marked communication serves as an ostensive cue that signals to the child that socially generalizable and personally relevant information is being communicated, effectively inviting the child to suspend epistemic vigilance to make use of helpful social information (Fonagy & Allison, 2014; Fonagy et al., 2015). When the caregiver mentalizes the child, it opens the *epistemic (or learning) highway* for the child. It communicates to the child that the

information the parent is conveying is important, relevant to them, and helpful. In a state of epistemic trust, the child is therefore able to accept culturally transmitted knowledge from the caregiver. The child is learning!

As it turns out, *learning is rewarding.* Brain research has shown dopamine increases when a person perceives stimuli that predict rewards. And dopamine feels good. Dopamine is what is released when people inject drugs, when they gamble, when they make love, and when they win (Ross, Sharp, Vuchinich, & Spurrett, 2008). These dopamine spikes are a dominant mechanism of reward learning within the brain (hence their addictive power). Recall our example earlier in this chapter when we recounted how a mother talks to her baby after her baby just woke up. Mom says: "Let me pick you up . . . oh, you feel nice and warm . . . are you hungry? Let's get your bottle ready . . . yes . . . it's breakfast time . . . see, it's light outside . . . come, let me hold you like this and we go get your bottle." In this example, the baby is pairing morning time with her bottle—the latter being rewarding (not to mention Mom's warmth when being picked up and cuddled). Over time, her brain begins to *expect* her bottle when it is morning time—just like Pavlov's dogs salivate when they hear a bell ring. We call this reward expectancy. She has learned to expect her bottle, and neuroscience tells us that every time we expect a reward, dopamine fires. It therefore makes sense that some neuroscientists have called dopamine a "learning signal" (Glimcher, 2003).

This simple example illustrates how a baby learns that morning time has something to do with breakfast time. It is important to note, however, that the baby cannot learn this information alone. Her mother teaches her this information by *mediating* the baby's subjective experience (hunger). In essence, the mother is mentalizing the baby's internal states. If she gets it right, what the baby learns is important (I'm hungry!), relevant (it's me who is hungry, not my mom!), and helpful (if I go with my mom I will be fed). To repeat, the knowledge gained from the interaction with Mom is important, relevant, and helpful. In turn, because this knowledge, over time, turns out to be important, relevant and helpful to the child, and because dopamine fires while she learns, *the child learns that learning is rewarding,* and begins to seek out learning herself. Pnina Klein and colleagues suggest that the child's **needs system** is stimulated

through this kind of mediated learning (Klein, 1996; Sharp et al., 2020; Sharp & Marais, 2022). What that means is that the child develops a *need* to (1) seek clarity of perception, (2) search meaning and excitement, (3) have successful experiences and complete tasks, (4) seek information beyond sensory experiences, explore, and ask adults for help, and (5) think before doing. In sum, the child becomes an *agentic learner* who can make use of the environment outside the home (school, peers, extracurricular activities, and so on) to further learn how to live effectively and happily.

With the introduction of the epistemic trust concept, Fonagy and colleagues suggest that *mentalizing is closely connected to learning*. Without consistent and sensitive caregiving, individuals may remain insulated from important learning experiences, which contributes to the cognitive rigidity that is one of the hallmarks of several forms of psychopathology, in particular personality pathology. It is to this topic that we turn to next in Chapter 4: difficulties in mentalizing—and ultimately, difficulties in learning from experience, as well as from the social environment.

CHAPTER SUMMARY

In this chapter, we aimed to increase your understanding of the developmental origins of mentalizing capacity. Doing so is important because in order to understand how mentalizing development goes awry in psychopathology, we must first understand its typical (normative) development. As we have shown, the capacity to mentalize is the culmination of several developmental prementalizing steps toward mature mentalizing. The prementalizing modes that precede the onset of mature, adultlike mentalizing are teleological mode, psychic equivalence, and pretend mode. As you will see in Chapter 4, these prementalizing modes, while developmentally appropriate in preadolescent children, can be considered maladaptive “nonmentalizing” modes when they predominate mentalizing in adulthood. This chapter also emphasized that mentalizing capacity does not develop in a vacuum, but that the early caregiving environment (and later on, the social environment writ large) provides a critical laboratory for the practicing of mentalizing skills throughout development. Thus,

mentalizing is rooted in attachment relationships inside and outside the home environment. We showed that it is through parental mentalizing (or **reflective function**) and, in particular, marked mirroring, that the infant, child, and adolescent gain the capacity to mentalize. Parental mentalizing fosters in children a feeling of being understood, which in turn engenders epistemic trust in the environment as a source of social learning.

CHAPTER 4

Difficulties in Mentalizing . . . and Difficulties in Learning

Chapter 3 outlined the reciprocal processes between parental mentalizing, attachment and epistemic trust, which in turn, facilitate socioemotional learning from the parent. We discussed how a mentalized child is able to openly accept instruction from his parent (which later generalizes to teachers, other adults, and peers) for fundamental knowledge about the world, including knowledge about the mind—not only the minds of others, but also his own mind. As the child matures, this trusted knowledge is used to flexibly respond to the growing complexity of his socioemotional world. As an infant and preschooler, he relied heavily on his primary caregivers to translate the interpersonal and intrapersonal context, such that his primary caregivers fulfilled an indispensable self-regulatory function. But as he matures, his needs system is stimulated to seek out knowledge so that he can learn himself. He begins to internalize the "caregiver as reliable source of knowledge" so that he himself becomes a reliable source of knowledge. Essential to the "felt security of knowing" about the self (Sharp et al., 2020), the world, and the future is the knowledge (derived from his caregivers) that he can respond flexibly to new challenges. By having been mentalized, he knows what mentalizing looks like and he can mentalize himself. When faced with challenges, he knows how to *slow down*, *reflect* on his mind and the minds of others, *learn* from the environment, and *adapt* to the new challenge. In short, this is what *resilience* is—*adaptability and flexibility*, and

it is mentalization (reflective **slowing down**) that facilitates it. With this, an agentic, self-determining author of the self begins to emerge in adolescence (McAdams, 2015) and we begin to see the consolidation of identity and the ability to manage both self and interpersonal function. But what if, for some reason, the capacity to slow down and learn never developed? Or developed in restricted ways?

MENTALIZING PROBLEMS ASSOCIATED WITH PERSONALITY CHALLENGES

Through sensitive caregiving, the child comes to understand his own mind and those of others, predicated on the notion of self and others as psychological agents—persons rather than objects. Therefore, the child first becomes aware of the existence of the mind by relating to others (interpersonal), from which his understanding of his own mind (intrapersonal) gradually emerges (Allen et al., 2008; Kim, 2015)—a process cogently described by others as learning "from the outside in" (Carpendale & Lewis, 2004; Stern, 1985; Vygotsky, 1980). This forms the basis of integrated and coherent personality functioning. But what if the transactional process of attachment, sensitive caregiving, parental mentalizing (marked mirroring), and epistemic trust is disrupted in some way? What happens if the early environment fails, for whatever reason, to provide a context in which the child is allowed to develop the ability to mentalize and regulate? In this section we briefly review literature linking attachment, mentalizing, and personality psychopathology.

Learning from the outside in: the child becomes aware of the existence of the mind by relating to others.

While mentalizing impairment has been shown to play an important role in various psychiatric disorders that involve pathology of the self and interpersonal relatedness (Sharp, Fonagy, & Goodyer, 2008), including autism, externalizing behavior, eating disorders, posttraumatic stress disorder, depression, and somatic disorders (Brune & Brune-Cohrs, 2006; Sharp & Venta, 2012), the paradigmatic disorder for attachment-based mentalizing impairment is BPD. Therefore, for illustrative purposes, we focus specifically on BPD to demonstrate one form mentalization difficulties can take and its origins.

For the purposes of justifying a diagnosis of BPD, understand that Section II of DSM-5 describes it from a categorical perspective and requires the clinician to evaluate whether a person meets at least a threshold level (five or more) of a range of criteria (American Psychiatric Association, 2013). As we explained in Chapter 1, in addition to this more traditional understanding of the disorder, psychopathology researchers, clinicians, and others have argued for a different approach—specifically, a hybrid categorical–dimensional approach to diagnosing personality disorders based upon both maladaptive self and interpersonal function *and* pathological personality traits. There is a growing consensus in the field that personality disorders exist along a spectrum of personality pathology, with individuals presenting varying degrees of symptoms and severity, leading to varying degrees of distress and functional impairment. Within this hybrid model, an important consideration is the assessment of the coherence of an individual's sense of self (identity), his sense of himself as an active agent who identifies with his behaviors (self-direction), his ability to understand the internal experiences of others (empathy or mentalizing), and his capacity for closeness and trust (intimacy). This feature of personality function cuts across *all* personality disorders; that is, for any personality disorder to be diagnosed, a person must display problems in self and interpersonal function. This feature therefore constitutes what is *common* among all of personality pathology and therefore an important indicator of personality pathology.

Beyond the fact that BPD is the paradigmatic disorder for understanding mentalizing impairment, it also turns out that BPD represents what is common to all of maladaptive personality function. In a study we published in 2015, Lee Anna Clark, Aidan Wright and our collaborators showed that if you factor analyze all of the symptoms of the most common personality disorders, the symptoms of BPD do not form a separate disorder, but instead load onto a general factor of personality pathology (Sharp et al., 2015). A good analogy to think of in this regard is intelligence. We know that there are different but related forms of intelligence. A Wechsler intelligence test would therefore consist of multiple subtests assessing the components of general intelligence. But what people are often most interested in is where a person lies on the general (*g*) factor of intelligence, which is dimensionally distributed in the population and shaped like a bell curve. We referred to this general intelligence as IQ. When we make policy

decisions or educational placements, we use IQ (the general factor underlying all forms of intelligence) to guide our decisions.

It turns out there is a general factor for maladaptive personality function as well; and what our study showed was that DSM-based BPD criteria seem to capture this general factor well. Criterion A and BPD therefore share a status as indices of what appears to be common or general for all personality pathology, which further justifies the attention we give to BPD and maladaptive self and interpersonal function (Criterion A of the Alternative Model for Personality Disorder) when considering how mentalizing deficits emerge and are maintained.

Empirical research bears out these expectations. Over a decade of research demonstrates mentalizing impairment in BPD (Fonagy & Luyten, 2009, 2016; Jeung & Herpertz, 2014; Sharp, 2014; Sharp & Kalpakci, 2015). Unlike individuals with autism-spectrum disorders, patients with BPD do not show mentalizing impairment when engaged in simple mentalizing tasks but evidence impairment when experimental tasks contain salient attachment- or self-relevant affective components or when the cognitive complexity of the task increases (Dyck et al., 2009; Minzenberg, Poole, & Vinogradov, 2006). Patients with BPD also do not appear to have impairment in mentalizing tasks that focus solely on external cues (like the eye region of the face) and may even outperform healthy controls in this regard. However, when simple external cues and features have been integrated with reflection on more complex mental interiors or when the mental interior of another person or the self is the main focus of the experimental task, clinically significant mentalizing difficulties in patients with BPD are observed. A good example of such a task was the one that we presented in Chapter 2 (the trust task). In this task, borderline patients had to navigate multiple modalities of communication. They had to keep track of the behavior of their interaction partner (whether they are receiving high or low offers); their own earnings compared to the earnings of their partner over the course of the 10-round game; their own emotions as they receive high or low offers and the regulation of those emotions; the effect of their partner's behavior on their emotions; and the effect that their own behavior (magnitude of return offers) might have on their interaction partners. In this study, we saw how the mentalizing capacity of

individuals with BPD starts to fall apart, impeding their ability to coax their partners back into the game after low offers were sent. Instead, they withheld offers to their partners, and we saw a breakdown in cooperation, hurting both partners, and ultimately, the game relationship.

Consistent with these findings, other studies have shown that individuals with BPD also appear to have problems in tasks that require controlled (conscious, explicit, deliberate or reflective) mentalizing especially under circumstances of high arousal. They also tend to overrely on gut feelings (implicit mentalizing), known to impede empathic understanding. Finally, with regard to failure to achieve balance between the two extremes of self versus other mentalizing, Frick et al. (2012) found that in the context of an emotion recognition paradigm, while individuals with BPD had superior facial emotion recognition, they also had associated increased activity in the left inferior frontal gyrus. This brain region is believed to be a part of the mirror neuron system associated with the understanding of motor events and their intentions. This suggests a greater resonance with the others' mental states in BPD, in contrast to healthy controls who showed greater activation in the insula and superior temporal gyri, areas typically associated with mental state discrimination. This merging of self and other in BPD is described by Fonagy and Luyten (2009) as a lack of agency associated with BPD and a subsequent overidentification with the mental states of others.

In summary, the observed mentalizing impairment in BPD (as a proxy for more general maladaptive personality function) is understood to result from a failure to achieve a *balance* between the two extremes of four polarities that underlie mentalizing capacity (Fonagy & Luyten, 2009, 2016). These polarities were discussed in Chapter 2, but we remind you of them again here:

1. Cognitive (e.g., "A thinks B thinks he is doing this on purpose") versus affective mentalizing (referring to the emotional connection between two people)
2. Mentalizing based on external (e.g., relying on the eye region of the face to know what someone is thinking) versus internal (e.g., considering what someone else might be thinking or feeling without having to see them) features of self and others

3. Automatic (outside of explicit consciousness) versus controlled (actively, intentionally, and consciously reflecting on the mind of self and other) mentalizing
4. Mentalizing with regard to self (e.g., “I know I’m a failure”) versus others (e.g., “He is definitely doing this on purpose”)

There is some evidence that each of these polarities is associated with its own underlying neural circuitry (Lieberman, 2007). In BPD, the failure to achieve balance between the different polarities of mentalizing results in *rigid responses to emotions and cognitions in self and others* that are insensitive to a changing environment. In other words, to mentalize, not only do we need balance between polarities, but we need to flexibly adjust that balance as the interpersonal situation changes. Borderline individuals struggle to maintain executive control over cognitive processing during emotionally intense interpersonal interactions, which inhibits fluid movement along the mentalizing polarities as demanded by the situation (Sharp, 2014). The end result is an inability to adaptively modify social-cognitive processing in a contextually appropriate manner that maximizes fitness with environmental demands.

MENTALIZING PROBLEMS IN OTHER DISORDERS: HYPERMENTALIZING, HYPOMENTALIZING, AND NO MENTALIZING

Before explaining how mentalizing development goes awry, we will pause briefly to discuss mentalizing problems in other disorders. We focused in more detail on BPD, just because BPD is at its core a disorder of mentalizing and therefore perhaps the best example of where mentalizing goes awry (that is, the paradigmatic example). In fact, the first clinical application of mentalizing was published by Peter Fonagy in the *Bulletin of the Menninger Clinic* in 1989 and titled “On Tolerating Mental States: Theory of Mind in Borderline Personality” (Fonagy, 1989). Since then, however, much research has demonstrated the ways in which mentalizing can be affected in depression, anxiety, substance use, conduct disorder, psychopathy, antisocial personality disorder, narcissistic personality disorder, attention-deficit/hyperactivity disorder (ADHD), eating disorder, and psychotic disorders. Because mentalizing is a multi-component

construct, each psychopathology appears to be associated with its own unique **mentalizing profile**.

Research is currently validating many of the clinical hypotheses in this regard, but to give you a taste of what we mean by unique profiles, we will give you an example of the differential outcomes of using a particular mentalizing task, the Movie Assessment for Social Cognition (MASC) (Dziobek et al., 2006). When Dziobek developed this task, she essentially introduced three types of mentalizing errors: excessive ToM, too little ToM, and no ToM. We then revised his terminology based on some literature on schizophrenia to describe the following mentalizing errors (Sharp. 2014; Sharp & Vanwoerden, 2015):

- **hypermentalizing** (excessive ToM): the overuse of mental state language to explain and predict behavior, which can present as a shift from the curious, inquisitive not-knowing stance of mentalizing into something more akin to intrusive mind reading)
- **hypomentalizing** (too little ToM): the use of thin, poorly articulated, simplistic, or ill-fitting assumptions about intentional states to explain and predict behavior, often inaccurately)
- no mentalizing (no ToM): a complete nonuse of mental state language to explain and predict behavior

The MASC is a computerized test and subjects are asked to watch a 15-minute film about four characters getting together for a dinner party.

Themes of each segment cover friendship and dating issues. Each character experiences different situations through the course of the film that elicit emotions and mental states such as anger, affection, gratefulness, jealousy, fear, ambition, embarrassment, or disgust. The relationships between the characters vary in the amount of intimacy (friends–strangers) and thus represent different social reference systems on which mental state inferences have to be made. During administration of the task, the film is stopped at 45 points during the plot, and questions referring to the characters' mental states (feelings, thoughts, and intentions) are asked (e.g., "What is Betty feeling?" "What is Cliff thinking?"). Participants are provided with four response options: (1) a hypermentalizing response, (2) an

undermentalizing (hypomentalizing) response, (3) a no mentalizing response, and (4) an accurate mentalizing response. To derive a summary score of each of the subscales, points are simply added, so that, for instance, a subject who chose mostly hypermentalizing response options would have a high hypermentalizing score. Similarly, participants' correct responses are scored as one point and added.

Our group was the first to use the MASC in a borderline population, and we discovered that adolescents with BPD tended to hypermentalize (Sharp et al., 2011). Put differently, we showed that teens with high borderline traits were able to mentalize, but they did too much of it. We further elaborated the construct to refer to "social-cognitive processing that involves making assumptions about other people's mental states that go so far beyond observable data that the average observer will struggle to see how they are justified" (Sharp et al., 2012), or the "overattribution of mental states to others and their likely misinterpretation" (Sharp et al., 2012). Since that first publication, several other groups have shown that individuals with BPD tend to hypermentalize (Andreou et al., 2015; Quek et al., 2018; Quek et al., 2019; Vaskinn et al., 2015). For clinical illustration of hypermentalizing, in Box 4.1 we provide an excerpt from a therapy session (Bo et al., 2015).

Box 4.1. Hypermentalizing

Gina was a 17-year-old girl who had been diagnosed with BPD, ADHD, and moderate depression. She lived in an institution and had only sporadic contact with her family. At the age of 11 she had been removed from her family due to their incapacity to take care of her. Before beginning therapy, Gina had made four serious suicide attempts, and she was hospitalized for long periods each time. She had been self-harming on a regular basis for 2 years and had a difficult time regulating her emotions in relation to both health workers and friends. Gina had expressed clear goals for her future, which included a career working with vulnerable adolescents, and at the time of her therapy she was enrolled in high-school-level courses. Gina had recently broken up with her boyfriend and was struggling to recover from the breakup.

THERAPIST: So tell me about the difficult situation when you met with your ex-boyfriend . . . it seems to me that it was a bit frustrating for you to meet with him, is that right to put it that way?

GINA: He met with me just to see that I was still in pain.

THERAPIST: What was it like for you to meet with him?

GINA: Awful . . . I mean . . . I spent two hours in hell . . . he kept telling me about his life, and that he is going out and has a lot of new friends . . . so annoying . . . I hate him and he doesn't respect me, just wants to bug me.

THERAPIST: That doesn't sound nice . . . did you feel anything in particular in that situation?

GINA *(talks loudly and seems agitated)*: I fucking told you I HATE HIM . . . what is it you don't get?

THERAPIST: Wow . . . it seems to me that you are upset about what happened . . . sorry, it wasn't my intention to annoy you.

GINA *(talks loudly and fast)*: You all say you're sorry, but it is a lie . . . John [ex-boyfriend] says he is sorry that we could not stay together . . . bullshit . . . he is not sorry about anything . . . Lisa [Gina's contact person at the institution] says she wants to help me and tries to understand me all the time . . . she is not trying to understand anything or help anyone . . . you and all this mentalizing . . .

THERAPIST: Hold on, hold on for a second, Gina, this goes really fast, and I can't quite figure it all out . . . can we please pause for a second, and look at what happened here?

GINA: I don't want to pause anything, I know what you are up to, you want to blame me, tell me it is my own fault, that I have to work with myself, that we should try and look at it together *(makes a face)* . . . no way, you obviously don't want to help me, that is clear . . . you just want talk, I need action, action . . . Lisa doesn't like me, I know for a fact, and Carl [head of the institution] ignores me on purpose. *(Gina starts to cry.)*

As demonstrated in this example, a vicious cycle between hypermentalizing and emotional dysregulation escalates as the session proceeds. Supporting these clinical observations, we have shown hypermentalizing to be related to increased levels of emotion dysregulation, which in turn associates with the likelihood of high levels of BPD (Sharp et al., 2011). This tendency is present in all psychiatric patients, but significantly more so in borderline patients (Penner, McLaren, Leavitt, Akca, & Sharp. 2020). Moreover, the tendency to hypermentalize appears to mediate the relation between attachment security and borderline symptoms. Hypermentalizing, rather than

emotion dysregulation, has been found to be the key factor in linking attachment security and borderline symptoms (Sharp et al., 2015). In one study in an inpatient setting, a reduction in hypermentalizing (but not other forms of mentalizing) from admission to discharge appeared to be associated with a reduction in adolescent borderline symptoms (Sharp et al., 2013). The presence of hypermentalizing can also distinguish between adolescents with BPD, adolescents with other psychiatric disorders, and healthy control adolescents on the basis of self-report (Sharp, Barr, & Vanwoerden, under review). Finally, mentalizing of the self was found to predict an increase in borderline symptomology over the course of a 1-year follow-up period in 881 adolescents recruited from the community (Sharp, Kalpakci, Mellick, Venta, & Temple, 2014). In this study, we used a measure of experiential avoidance to operationalize mentalizing the self.

Clearly, the evidence for hypermentalizing in BPD is strong. In contrast, research using the MASC has shown that hypomentalizing compared to hypermentalizing seems to correlate with autism severity (Martinez et al., 2017). In other words, individuals with autism will be less likely to over-attribute mental states to others (hypermentalizing) and would be unlikely to use mental state language to explain and predict behavior—a state that Simon Baron-Cohen referred to as *mind-blindness*. For schizophrenia, there appears to be evidence for both hypomentalizing (Andreou et al., 2015; Montag et al., 2011; Peyroux et al., 2019; Vaskinn et al., 2015) and hypermentalizing errors (Martinez et al., 2017; Montag et al., 2011; Vaskinn et al., 2015). Interestingly, in schizophrenia, hypermentalizing is said to be a maintaining mechanism for positive symptoms, like delusions and paranoia, by way of personalizing attributions, or the tendency to blame people rather than situations for negative events (Penn et al., 2008). On the other hand, negative symptoms, like anhedonia and amotivation, are thought to be related to reduced ToM, which extinguishes social reinforcement thereby increasing negative symptoms. Following from this literature, we recently conducted a study in which we used a combination of variable-based and person-centered analyses to determine class membership of adolescents based on variation in social cognition, psychopathology, and family functioning. We identified five latent

Individuals with BPD tend to hypermentalize.

classes: two internalizing groups, two externalizing groups, and a severe psychopathology group—each differing in type of mentalizing (hypermentalizing vs. hypomentalizing) (Gambin, Gambin, & Sharp. 2015). Figure 4.1 captures our findings visually.

To conclude, a large literature describes the use of a myriad of other mentalizing tasks to differentiate mentalizing profiles in a range of disorders. A review of this literature is beyond the scope of this volume. What we want to emphasize is that mentalizing impairment manifests differently for each dimension of psychopathology. Accordingly, there may be different developmental pathways by which mentalizing goes awry for each disorder. For instance, the genetic influences on social-cognitive function may be greater in autism and schizophrenia, while the environmental influences may be greater for BPD. These are empirical questions, and we do not simply assume this to be true.

With that, we are now ready to consider the roots of maladaptive mentalizing. Before we do so, we want to alert the reader to another important development in research evaluating the links between classes or dimensions of disorders and different forms of mentalizing. Earlier, we described the general factor of personality disorder

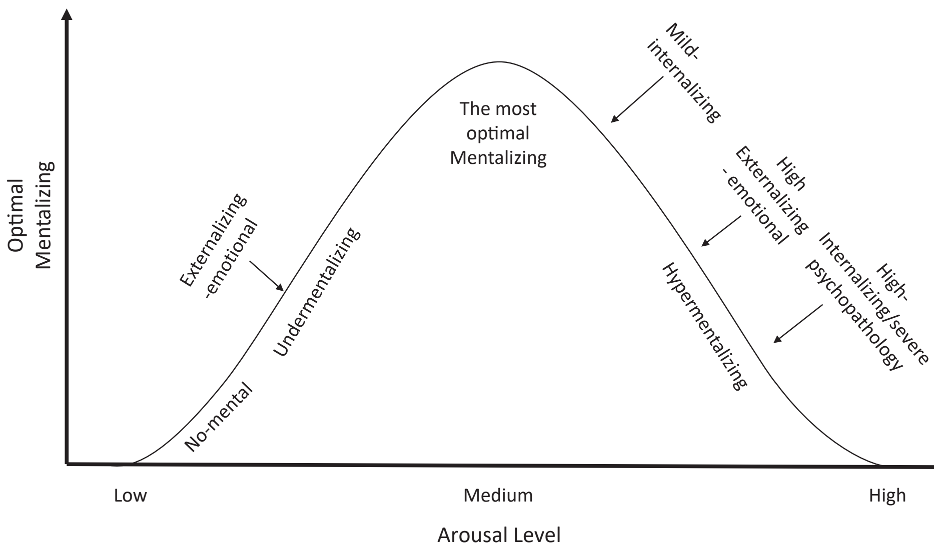


FIGURE 4.1. Mentalizing styles and dimensions of psychopathology.

(*g*-PD). It turns out that a general factor for all psychopathology has also been identified—the so-called, "psychopathology factor" (or "*p* factor"; Caspi et al., 2014). The idea of the *p* factor developed out of the observation of high covariation among symptoms of psychopathology. Comorbidity among discrete disorders is the rule rather than the exception, suggesting that covariance between different types of psychopathology is better explained by latent dimensional constructs (internalizing, externalizing, and psychoticism). However, correlations between especially internalizing and externalizing disorders are so high that it suggests an even higher-order latent factor in the metastructure of psychopathology. Accordingly, factor-analytic studies have shown that this covariation among symptoms is best explained by a general factor (the *p* factor) similar to the *g* factor of intelligence or the *g* factor of personality pathology. In addition to the *p* factor, a set of specific factors (*s* factors) denote specific disorders or spectra (like the internalizing, externalizing, and psychotic spectra). While the exact nature of the *p* factor is still being evaluated, it is reasonable to argue that the *p* factor, at the least, denotes overall severity in psychopathology. In other words, the *p* factor denotes in particular the proneness to chronicity and functional impairment. Conversely, Fonagy and colleagues have argued that low scores on the *p* factor are an *index of resilience* (Fonagy, Luyten, Allison, & Campbell, 2017a, 2017b). Fonagy explains that resilience associated with low *p* factor scores is best understood as a function of the relation between the social environment as a system on the one hand, and individual differences in mentalizing capacity on the other. Implied is the assumption that mind-reading deficits alone cannot drive psychopathology, but that psychopathology must be the result of entrenched adaptation to stimuli from the social environment. Put differently, mind-reading deficits or impairment often arise from desperate attempts of an individual to adapt to an impossible environment—"a learned expectation about cultural context" (Fonagy et al., 2017a, p. 2). Thus, psychopathology denotes an inflexibility in the human capacity for social communication and learning, and associated impermeability to the help offered in the form of evidence-based treatments. Conversely, when protective factors afford an individual with adequate mind-reading capacity, the individual is able to make use of social learning opportunities thereby building resilience, including the capacity to absorb the help on offer from evidence-based treatments.

We will now use BPD as the paradigmatic disorder to illustrate our points. But as you read this, do keep in mind that BPD is a good general index of maladaptive personality (Criterion A) function, more broadly defined.

HOW DOES ATTACHMENT-BASED MENTALIZING DEVELOPMENT GO AWRY?

The first and most obvious pathway to disruption of the development of adequate mentalizing capacity is through caregiver maltreatment (Cicchetti & Toth, 2005; Fonagy & Luyten, 2016). Attachment trauma, including caregiver maltreatment, represents complete failed mentalizing or mind-blindness on the part of the caregiver (Kim, 2015). To inflict maltreatment, the parent must close his mind to the mind of the child. The child is no longer a psychological agent with thoughts, feelings, needs, desires, and fears. Without recognition of his own mind in the mind of the caregiver, the development of mentalizing capacity in the child is stifled. Accordingly, maltreated children show delays in ToM development (Cicchetti, Rogosch, Maughan, Toth, & Bruce, 2003), poor affect regulation (Kim & Cicchetti, 2010), reduced references to their internal states (Shipman & Zeman, 1999), and poor emotion understanding (Cicchetti & Curtis, 2005).

While maltreatment undoubtedly denotes one pathway to stifle mentalizing development, recent reports suggest that for BPD specifically, emotional neglect and abuse in isolation or as part of physical/sexual abuse are more toxic than physical/sexual abuse per se (Fonagy & Luyten, 2016). Moreover, as suggested by Linehan's (1993) biosocial theory of BPD, *perceived* or actual invalidation by caregivers, even in the absence of direct maltreatment, is enough to play a central role in the development of borderline traits in offspring who are temperamentally (biologically) sensitive. A parent may not be intending invalidation at all, but because a child may be sensitive, an utterance as simple as "Please put away your shoes" may be interpreted or *felt* as being invalidating. In such cases the subjective experience remains that of attachment trauma. So how does this work? Figure 4.2 adapted from Fonagy & Luyten (2009) summarizes how attachment, mentalizing, and the development of self interact to produce

prementalizing modes and ultimately personality pathology. In this figure you will notice distal factors (constitutional/temperamental factors and early caregiving context factors). These factors interact when children are young (and through the course of their development) to cause **attachment disruptions** between a primary caregiver and the child.

Indeed, as we saw in the description of the normative development of mentalizing, attachment is the child's early laboratory for learning and practicing mentalizing. Thus, attachment disruption, which is usually associated with reduced parental mentalizing, results in the child not learning that his mind is separate from his mom's (or dad's) mind. *Poor self–other differentiation* emerges and leads to a confusion between "my mind" and "my mom's mind" and a hypersensitivity to mental states of others. The child learns that the mind is a dangerous place that is either best avoided or should be obsessively attended to. Attachment contexts become settings of vulnerability instead of safety, and the child develops a *low threshold for attachment activation,*

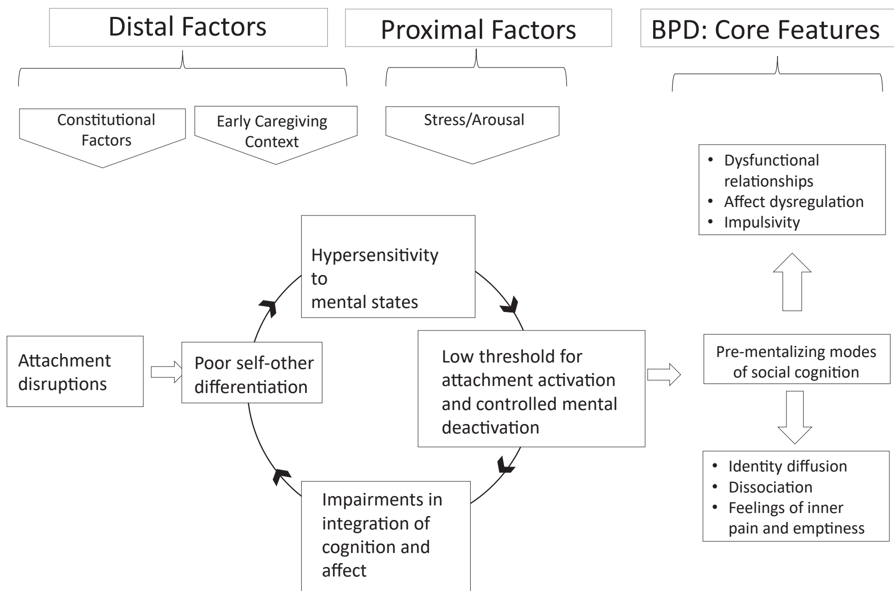


FIGURE 4.2. The mentalization-based model for the development of personality pathology. Adapted with permission from Fonagy and Luyten (2009).

meaning that he becomes easily overwhelmed when attachment schemas are activated and struggles to down-regulate mentalizing in a controlled fashion (leading to hypermentalization). This, in turn, leads to thwarted efforts to integrate complex cognition and affect, escalating emotion dysregulation. Together, these cyclical processes of poor self–other differentiation, hypersensitivity to mental states, low threshold for attachment activation and controlled mental deactivation, and impairments in integration of cognition and affect become the central engine that is activated by proximal stress (usually in the interpersonal domain). This central engine then activates prementalizing modes of social cognition that manifest in the symptoms of BPD (or Criterion A personality function, i.e., maladaptive self and interpersonal function).

It is important to grasp the meaning of the prementalizing modes because you will be using them to design and select mentalizing interventions during your therapy sessions. Recall in Chapter 3, we described the three prementalizing modes (teleological mode, psychic equivalence, and pretend mode) as normative social-cognitive reasoning phases associated with infancy, toddlerhood, and middle childhood. When children reach adolescence, they gain the metacognitive (abstract) capacity to move beyond prementalizing modes and to engage in mature mentalizing. However, as we saw in the husband-and-wife example of Chapter 2, and the homework example of Chapter 3, we all have the capacity to slip back into a prementalizing mode at any point, even as adults—usually when our emotions run high. We become momentarily mind-blind and our prefrontal cortex no longer can assist in making sense of what is happening. It is at this point that we refer to the prementalizing modes as *nonmentalizing* modes. In an infant, we do not consider teleological thinking as nonmentalizing, because the infant does not have the cognitive capacity for mature mentalizing. But when we see teleological thinking, psychic equivalence, or pretend mode in a 40-year-old, we consider it nonmentalizing, because we know that as an adult, the individual *has* the capacity for mature mentalizing but has temporarily lost it.

We all can slip back into a prementalizing mode, usually when our emotions run high.

Thus, in mentalization-based therapies a major goal for the therapist is the identification of nonmentalizing modes as a first step in

deciding how to intervene, so it is important that you have an understanding of these modes. Before we elaborate on the nonmentalizing modes, we want to stretch the developmental model presented in Figure 4.2 just a bit further to also incorporate the concept of epistemic trust that we referred to in Chapter 3. Recall that epistemic trust refers to the child's belief that the information a caregiver transmits to him is important, relevant, in his best interest, and helpful. Attachment trauma, and the associated central engine we described above, whether real or perceived, obliterates epistemic trust, foreclosing the most important channel for receiving self-relevant information about the world (Fonagy & Allison, 2014; Kim, 2015). It stifles learning about the mind, and the individual is deprived of the *felt security of knowing* about the self, others, and the world. The result is an impoverished agentic self and a personality structure that is unstable and vulnerable to external events. In the absence of a solid center that can flexibly respond to the environment, the individual with BPD rigidly holds on to the same response irrespective of a changing context. Rigid inflexibility in responding and adapting alternative positions in response to a changing context has been identified by most theories of personality and personality pathology as central to the definition of personality disorder (Beck, Freeman, & Davis, 2004; Kernberg, 1984; Luyten & Blatt, 2011; Rogers, 1961). Elsewhere (Sharp et al., 2020), we used Bayesian updating as a metaphor to describe this process of learning. In Bayesian modeling, Bayes' theorem is used to update the probability for a hypothesis as more evidence or information becomes available. It is essential for the dynamic analysis of a sequence of unpredictable data. In life, there are few things as unpredictable as our interpersonal interactions, which rely on a myriad of stochastic (randomly distributed so that pinpoint prediction is impossible) variables acting together. For the individual with BPD, updating of information does not take place as new information flows into the system because "epistemic freezing" (Kruglanski & Webster, 1996) or "petrification" (Fonagy et al., 2015) has occurred. The individual with BPD does not know whom to trust and closes himself to socio-emotional learning. He cannot trust himself or his attachment figures and consequently is constantly vulnerable to feeling hopelessly abandoned and alone.

This rigidity is displayed in the three *prementalizing or nonmentalizing modes* and we can now elaborate further on this. Recall that

we discussed these modes in Chapter 3 when we introduced the normative developmental timeline for mentalizing. Again, we emphasize that these prementalizing modes denote mentalizing that *developmentally* precedes mature adultlike mentalizing. The first, the psychic equivalence mode (of which hypermentalizing [Sharp. 2014; Sharp et al., 2013; Sharp & Vanwoerden, 2015]) forms a subtype), denotes a stance in which thoughts and feelings become too real and internal experience is *equated* with external reality. In the same way that a 3-year-old feels there *is* a monster under the bed because he *thinks* there is a monster under the bed, a typical cognition exemplifying this mode in a client with BPD may be "Because I *feel* hurt, *it must be true* that he was intentionally trying to upset me." Reality is defined by affective self-experience at the expense of logic. Recall that in young children, we see psychic equivalence often expressing itself in the magical thinking of the preoperational child. A preschooler might, for instance, be wishing for a kitten and then believe that because he wished it, one will appear at his house.

The *teleological mode* refers to a focus on observable goal-directed behavior and objectively discernible events that may potentially constrain these goals. Recall the homework example discussed in Chapter 2. Mom was in the teleological mode because she suspended reflection on the mind of her 8-year-old in service of an urgent desire to achieve the goal of getting the homework done. Could she have found a way of achieving that goal while at the same time keeping her daughter's mind in mind? In BPD it might sound something like this: "I will only believe that he is not cheating on me if he always takes me with him on business trips." The teleological mode reflects an overfocus on the exterior aspects of mentalizing and a lack of reflective, deliberate mentalizing. As discussed in Chapter 3, developmentally, teleological thinking is evident in small children's understanding of the meaning physical objects have for them—for instance, a bottle of milk means it is feeding time. When it is light outside it means it is time to get up.

The pretend mode denotes instances in which thoughts and feelings become severed from reality. Thus, thoughts and beliefs are disconnected from authentic subjective and situated experiences in self and other. A person in pretend mode may *appear* to be discussing something psychologically meaningful, but further inquiry reveals the subtle signs of pretend mode, including overreliance on jargon,

intellectualization, circularity, or dissociation of affect. A cartoon metaphor would be to see a person's speech bubble expanding to block out any actual eyeline or connection between him and the other mind he is supposedly addressing; it's all words, words, words but with no connection. When a person is in pretend mode, one may mistake his mode for true mentalizing, given that he is likely to use mental state language, except that the content and tone of what he is saying may not ring true. A telltale sign is a disconnect between affect and content resulting in a certain lack of authenticity that reminds one, developmentally, of the apparent competence in toddlers trying out certain roles, for instance, being "a big girl." In the presence of somebody operating in pretend mode, it is easy to find oneself feeling distracted, disconnected, or even a little bored. This is more noticeable if the content of the other person's speech "should" by rights be filling the room (or at least me, the listener) with emotion.

The three prementalizing modes are summarized again with shorthand in the four lines below. It is important that you understand the difference between these modes, because as you will see, identifying when a client slips into prementalizing mode is the first step in delivering a mentalizing intervention.

> Teleological mode: Because I <u>see</u> it, it is true.
> Psychic equivalence: Because I <u>think</u> it, it is true.
> Pretend mode: Because I <u>act</u> like it, it is true.
> In contrast, the mentalizing mode is: I am <u>not certain</u> what is true and I am <u>curious</u> to find out.

ADOLESCENCE AS A SENSITIVE PERIOD FOR THE ONSET OF PERSONALITY DISORDER

In Chapter 3 we charted the developmental progression of typical development in mentalizing. We highlighted adolescence as a critical developmental period during which, in McAdams (2015) terms, the "binding" of personality occurs. As early as infancy, children differ in their personality (temperamental) traits. Some babies are easily soothed and smiley; others need a bit more from their caregiving environment to manage their arousal levels. While these individual differences are clearly observable in infants, and preadolescent

children, the meta-cognitive capacity is not yet present to integrate temperamental traits into a coherent and reflective sense of self. The monumental capacity for constructing a coherent, abstract, and integrated sense of self onsets only in adolescence. This is the time that individuals are able to construct a narrative identity that provides their life with a full sense of meaning, purpose and temporal continuity. In McAdams's model (2015), the stories we tell about who we are as a person (person-as-author) are layered over our values and goals (person-as-agent), which are layered over our dispositional (temperamental) traits (person-as-actor). McAdams points out that it is in storytelling that we, as self-conscious human beings, make sense of ourselves. To create meaning out of our traits, social performances, and motivated actions over time, we rely heavily on our capacity to mentalize (Sharp & Wall, 2021). It is therefore no surprise that adolescence is associated with dramatic and qualitative developmental shifts in the neurobiology of mentalizing (Pfeifer, Lieberman, & Dapretto, 2007). With the expansion of the social brain, in conjunction with qualitative (discontinuous) shifts in sexual maturity and identity and the mental representation of self, adolescents are poised for adult intimacy. However, when these aspects come together (*bind* or *thicken*) into a unidimensional severity continuum during adolescence, it comes at a price for some. For some adolescents who do not have adequate or optimal mentalizing capacity, these processes are derailed, resulting in a more general adaptive failure or delayed development of the meaning-making, intrapsychic system needed to fulfill adult life tasks. If mentalizing is impaired, the binding of personality is delayed or in some cases does not occur, resulting in an incoherent sense of self—in other words, personality disorder. Indeed, research over the last 10–15 years reviewed elsewhere (Chanen, Sharp, Hoffman, & Global Alliance for Prevention, 2017; Sharp, 2016; Sharp & Fonagy, 2015) has shown personality disorder to be as valid and reliable a diagnosis in adolescence as in adulthood, based on phenomenology, stability, and risk factors, marked separation of course and outcome from other disorders, and efficacy of disorder-specific treatment. However, personality disorder does not onset until adolescence, because it is only with the normative developmental emergence of integrated self and identity function that the potential for personality dysfunction emerges. Indeed, in collaboration with Majse Lind, we have begun to show the empirical links between maladaptive

identity, narrative identity, mentalizing, and personality pathology in adolescence (Lind et al., 2019, 2020). Taken together, it is critical that personality development in adolescents is explicitly scaffolded by the social environment, especially in young people with sensitive temperaments. Adult mediation of the subjective experience of self as adolescents begin to write the story of who they are as a person is the key to healthy personality development and the prevention of personality disorder.

In adolescence we develop the capacity to construct a coherent identity and sense of self.

CHAPTER SUMMARY

In this chapter, we have discussed how early attachment experiences can undermine our ability to experience epistemic trust. When we are not mentalized, we fail to develop the capacity to slow down and mentalize. Hypervigilance develops and our own and others' minds are seen as malevolent. Knowledge transfer is blocked; and once this happens, the mind is closed for knowledge acquisition—it cannot learn from new experiences; nor from the social environment. For those regularly working with individuals with personality challenges, this will be a familiar experience: the observation that your client struggles to learn new ways of doing things. In the mentalizing framework, we say that your client is struggling with a subjective sense of epistemic injustice (being misunderstood). He feels extremely isolated, alone, and disconnected, as if nobody can help him. It is perhaps this that has made BPD such a desperate disorder to have and to treat, because ultimately, due to the significant difficulties in mentalizing and learning, the individual with BPD cannot make use of therapeutic intervention. Peter Fonagy captured this well when he said that clients with BPD "hear, but they cannot listen." Hence, session content never gets generalized outside of the therapy room. We also discussed that adolescents are particularly vulnerable to feeling misunderstood and need extra scaffolding in their mentalizing capacity to help them build their personalities.

We can now circle back to the idea presented in Chapter 3, where we introduced the notion that for change and learning to take place,

the needs system must be stimulated (Klein, 1996; Sharp, Shohet, Givon, Marais, 2020). What that means in the context of therapy is that the client *himself* must experience a need to (1) seek clarity of perception, (2) search for meaning and excitement, (3) have successful experiences and complete tasks, (4) seek information beyond sensory experiences, to explore and to ask for help; and (5) think before doing (Sharp et al., 2020). By embodying a Mentalizing Stance, he must become an *agentic learner* who can make use of the environment outside the therapist's office to further learn how to live effectively and contentedly. In Chapter 5, we begin the process of demystifying mentalizing interventions to achieve these goals.

CHAPTER 5

Mentalizing Assessment and Formulation

As with any other psychotherapy, MBT begins with an assessment phase that is model specific. If you were doing CBT, you might spend a few sessions collecting thought records to get a sense of the types of thinking errors that a client may engage in. You do this by naturally folding in the idea of the link between thoughts, feelings, and behavior into the client's recounting of what has been going on for her (e.g., "So when she said she wants to break up with you, what was going through your mind at the time?"). If you were doing DBT, you might spend some time getting a sense of a typical behavioral chain that leads to problems for your client (e.g., "So right before you cut yourself, can you remember what was happening right at that moment?"). In MBT, instead of using a behavioral chain of events or an ABC formulation as the frame for your assessment, you use the idea of a mentalizing profile as your lens or frame. This means that in the first set of sessions with your client, you try to get a sense of the mentalizing capacity of your client so that you can use that as a starting point for your **mentalizing formulation** and ultimately the mentalizing interventions you will be using (Chapter 6). Getting a sense of your client's mentalizing capacity may take up to three sessions, after which you will build a mentalizing formulation. It is important to know that the assessment process itself is an intrinsic part of the treatment and should not be seen as separate from the treatment process. In essence, MBT involves *continued* assessment

of mentalizing capacity throughout a session and throughout the course of therapy. This chapter is concerned with teaching you the basics of assessing your client's mentalizing at the beginning of therapy so you can construct a mentalizing profile and formulation by the end of two to three sessions. We will return to the continuous assessment of mentalizing when we discuss the *mentalizing process* in Chapter 7.

You will remember from the material presented in Chapter 2 that while mentalizing may be considered a unitary construct ("She is a good mentalizer"), mentalizing is also a multicomponent construct. There are therefore multiple aspects of mentalizing that you will consider in building a client's mentalizing profile. These include:

MBT involves continued assessment of mentalizing capacity throughout the course of therapy.

1. Client's **overall mentalizing capacity** (good vs. poor).
2. Predominant **non- or prementalizing modes** and conditions for activation (psychic equivalence, teleological mode, pretend mode).
3. Predominant **mentalizing style** (hypermentalizing, hypomentalizing, no mentalizing).
4. Balance in **mentalizing polarities** (self/other; cognitive/affective; automatic-implicit/controlled-explicit; and internal/external) and conditions for activation.

THE ASSESSMENT OF OVERALL MENTALIZING CAPACITY

Table 5.1 contains indices of good and poor overall mentalizing capacity (adapted from Luyten, Malcorps, Fonagy, & Ensink, 2019).

Whether a person is engaging in good or poor mentalizing should be readily apparent in the way she talks about what has been going on for her. Below are some example excerpts from the first session with a client in response to the question "What has brought you to therapy?" For each, see if you can spot whether the client is engaging in good or poor mentalizing, and try to use Table 5.1 to articulate why or why not.

TABLE 5.1. Examples of Good and Poor Overall Mentalizing Capacity

Good Mentalizing	Poor Mentalizing
• Security of mental exploration and openness to discovery; internal freedom and interest in exploring even painful memories and experiences • Acknowledgment of the opaqueness and tentativeness of mental states • Genuine interest in the mental states of the self and others, and their relation • Adaptive flexibility in switching from automatic to controlled mentalizing • Acknowledgment of the changeability of mental states, including awareness of the developmental perspective (i.e., that the individual's own attachment history influences current ways of relating to self and others) • Integration of cognitive and affective features of self and others ("embodied mentalizing") • Sense of realistic predictability and controllability of mental states • Ability to regulate distress in relation to others • Relaxed and flexible, not "stuck" in one point of view • Can be playful, with humor that engages rather than hurting or distancing • Can solve problems by "give-and-take" between own and others' perspectives • Describes one's own experience, rather than defining other people's experience or intentions • Conveys "ownership" of one's behavior rather than a sense that it "happens" to one • Open to and curious about other people's perspectives, and expects to have one's own views extended by those of others	• Dominance of unreflective, naive, distorted, automatic assumptions • Unjustified certainty about internal mental states of self and/or others • Rigid adherence to own perspective or excessively flexible in changing perspectives • Overly focused on external or internal features of self and other, or complete neglect of one or both ("mind-blindness") • Inability to consider both self and other perspectives • Emphasis on either cognitive or affective aspects of mentalizing (i. e., overly analytical versus being overwhelmed by states of mind of self and/or others) • Excessively sparse or overly detailed mentalizing • Focus on external factors (e.g., government, school, colleagues, neighbors) • Focus on "empty," purely behavioral personality descriptors (e.g., "tired," "lazy") or diagnoses • Lack of interest in mental states, or defensive attempts to avoid mentalizing by becoming aggressive or manipulative, using denial, changing the subject, or otherwise being noncooperative (e.g., "*I don't know*") • Lack of reciprocity and turn-taking in communication

(*continued*)

TABLE 5.1. (*continued*)

Good Mentalizing	Poor Mentalizing
Relational strengths • Curiosity • Contemplation and reflection • Perspective taking (including the recognition that others may have different thoughts, feelings, and opinions) • Forgiveness • Impact awareness • Nonparanoid attitude • Reciprocity and turn-taking	
Perception of own mental functioning • Developmental perspective • Realistic skepticism • Internal conflict awareness • Self-inquisitive stance • Awareness of the impact of affect • Acknowledgment of unconscious and preconscious functioning • Belief in changeability	
Self-representation • Rich internal life • Autobiographical continuity • Advanced explanatory and listening skills	
General values and attitudes • Tentativeness • Humility (moderation) • Playfulness and humor • Flexibility • "Give and take" • Responsibility and accountability	

1. Well, I have just been very sad lately. I'm not sure why. A lot has changed recently, and I'm thinking that I might just be exhausted trying to adjust to everything. I'm trying to make sense of everything that has happened to me.
2. My mom sent me here.
3. Well, why do people come to therapists? To get help of course.
4. I'm here to try and figure out what to do about my husband. It has become unbearable to live with him. He is very demanding and

wants me to be available 24/7 for him. I cannot stand it anymore. I'm tired of taking care of him without getting anything in return. I would like to learn skills to manage him or get away from him.

5. Dr. Smith referred me to you. She said that I might be able to benefit from working with you. She was not able to help me because I'm too complicated. It's always been like this. There's this boy I like. I don't know . . .

All of the excerpts above (except for the first) indicate rather poor mentalizing. In some cases (e.g., #2) mental states of others or oneself are not considered at all. In other cases, automatic assumptions are being made (e.g., #4) or the narrative is generally incoherent (#5) or unreflective (#3). The first response is considered a mentalizing response because the client is demonstrating uncertainty while at the same time acknowledging her affective state and expressing a curiosity and desire to make sense of the effect of events on her. In responding to these statements, the therapist will gain a deeper understanding of the exact nature of the mentalizing impairment. The first assessment may refer to the prementalizing (or nonmentalizing) mode of the client.

THE ASSESSMENT OF PREMENTALIZING/NONMENTALIZING MODES

In Chapter 4, we covered the three prementalizing (nonmentalizing) modes: psychic equivalence, pretend mode, and teleological stance. To recap, a person is thought to be in psychic equivalence if she is certain and absolute in her thinking and defines reality according to what's in her mind, with complete disregard for any evidence in support of her perspective ("Because I think it, it is true").

Pretend mode is denoted by a lack of authenticity and a disconnect between content and affect. A client may, for instance, be talking about something upsetting in a flat and monotone voice as if she doesn't really care about it, while all other evidence points to the significance of the event for her, or she may offer rather intellectualized explanations that effectively deny the significance of something that from a different perspective looks important and impactful. Sometimes pretend mode reveals itself to a listener in recognizing her own sense of disengagement or even boredom that is evoked in listening

to an account. Sometimes the disconnect is between a description of (or justification for) a behavior and the minimizing of its observable (ordinarily distressing) real-world impacts—for instance, the heavy drinker who brushes off concerns ("Oh, everyone 'round here likes a drink!") while ignoring that she has lost her driving license and her partner has taken the children on account of her habit.

Teleological mode (concrete thinking) is indicated when a client requires worries or distress in the inner world to be resolved by visible, tangible outcomes in the physical world. Good examples include addressing psychic pain through self-harm, fear by running away, anger by violence.

In Box 5.1 we present an excerpt taken from Sharp and Rossouw (2019) where we indicate the various nonmentalizing modes represented by an adolescent's statements.

Box 5.1. Nonmentalizing

PETER: I broke up with Michelle. You remember that I wanted to see her last Friday, and she said she was busy. Later, I found out that she was only busy for 1 hour, and I could have seen her. So on Saturday, *I thought, I'm not having this; I may as well end it with her rather than wait around for her.* [teleological]

THERAPIST: What did you feel on Friday?

PETER: I sent her a text Saturday and said, "If you don't call me by 5 o'clock, it's over." I used to think that she wasn't answering her phone because it was broken, but, funnily enough, just after I sent the text, she texted straight back saying, "I am sorry, but I am a happy person, and you are always moaning, and it brings me down." *So I thought, okay, whatever, and just left it.* [pretend]

THERAPIST: Gosh, you must have felt very hurt.

PETER: No, I tried to convince myself that I felt nothing. I just don't understand; I was always happy when I was with her. *I don't see how she could say that I am always moaning. The only thing I moaned about was that she just never answered her phone. Any boyfriend would want that, right?* [psychic equivalence]

THERAPIST: So, when she didn't answer her phone, what did that feel like?

PETER: It felt as if she didn't care. *Jenny* [another ex-girlfriend] *always answered her phone, and that is how I knew she cared.* [teleological]

THERAPIST: And when you felt that she didn't care, how did that make you feel?

PETER: Anxious, *and then I would phone her nonstop, and I would text and leave messages* [teleological]. *It's not right to ignore me like this.* [psychic equivalence]

THERAPIST: So the more she didn't answer, the more anxious you would get.

PETER: Sometimes *I would call her 20 times* [teleological], and she would ignore me. *I know why*. [psychic equivalence]

THERAPIST: And when you were anxious, what thoughts did you have, and what were you anxious about?

PETER: *I think that she's met someone else* [psychic equivalence]. And I sort of saw it coming, so Friday evening, when I went dancing, *I flirted with people* [teleological], and then I met this new girl. She's not really new; she is sort of a friend. So I thought that I'd like to take her out, so I pretended to be drunk, and then I told her that I would like to take her out. I thought that if I pretended to be drunk and she said no, then I would just say the next day that I was drunk and that I don't remember anything. Then I won't have to feel embarrassed. So she didn't do that but said that she'd like to go out with me. On Saturday, *when I dumped Michelle, I already had the other one lined up, so I didn't really care about Michelle anymore* [pretend]. *Now life has moved on* [pretend], and this weekend I will go out with her for the first time. *And this week I felt really happy* [pretend]. *This girl is really special. We have so much in common; she is pretty . . .* [pretend]

THERAPIST: Can I just slow things down a bit to try and catch up?

PETER: Yes, it is a bit fast, isn't it? I always do that—I always have one in reserve. The minute I see trouble coming, I get one in reserve.

THERAPIST: It seems to me that all of this action about phoning her so many times and getting another girl in reserve are ways in which you try to manage a terribly anxious feeling inside you.

PETER: *Yes, but now I don't feel it because the new girl answers her phone all the time, so I know she likes me*. [teleological]

THERAPIST: You said that when Michelle didn't answer her phone, you got anxious. Is that all you felt, or did you have other feelings, too?

PETER: I felt anxious that she was seeing another guy *and then I phoned again and again.* [teleological]

THERAPIST: If I thought that someone I like was seeing someone else, it would make me feel angry.

PETER: Yes, I felt like I could smash my phone up. I wanted to break her door down.

THERAPIST: So part of phoning her so many times was also an angry thing.

PETER: Yes, I suppose it was a bit smothering; maybe that is why she said that I was moaning. *But any guy would be upset if he was ignored.* [psychic equivalence]

Reprinted with permission from Sharp and Rossouw (2019).

As is evident from the session excerpt in Box 5.1, clients do not stay in any one nonmentalizing mode for long, but tend to move quite quickly from one to another. The therapist's identification of the exact nonmentalizing mode is less important than the awareness that mentalizing has broken down. A good understanding of the three nonmentalizing modes aids in the awareness that a client is no longer mentalizing.

Often, the therapist's own subjective experience in response to the breakdown in mentalizing offers further help in identifying which nonmentalizing style a client may be engaging in. Of course it is important to remember that while we are here stressing the failures of mentalizing in a *client,* in the pressurized context of a therapeutic session, the therapist's *own* mentalizing is far from invulnerable. An experience in relation to nonmentalizing in a patient may often threaten the therapist's own capacity to hold a Mentalizing Stance, and we cover this in more depth in later chapters. Learning to expect this, and to be ready to own and mark such moments with transparency, humility, and perhaps a little self-deprecating humor thus facilitates real-time modeling by the therapist of mentalizing repairs. This is a key aspect to the power leveling that should occur in working this way—nobody sustains mentalizing with 100% accuracy and consistency, and it is often after a therapist's own temporary *loss* of mentalizing, recognition, and subsequent recovery that significant progress is made, precisely because this creates space for an experience of authenticity in the relationship. Table 5.2 summarizes therapist experience typically associated with each nonmentalizing mode that may help signal that the client stopped mentalizing.

Identifying the specific nonmentalizing mode is less important than recognizing that mentalizing has broken down.

TABLE 5.2. Therapist Experiences Typically Associated with Each Nonmentalizing Mode

Mode	Therapist's Experience
Psychic equivalence "Because I think it, it is true"	• Puzzled • Wish to refute • Statement appears logical but obviously overgeneralized • Not sure what to say, lost in argument • Angry or fed up and hopeless
Pretend mode "Because I act like it, it is true"	• Boredom • Detachment • Patient agrees with your concepts and ideas • Identification with your model • Feels progress is made in therapy
Teleological mode "Because I see it, it is true"	• Uncertainty and anxiety • Wish to do something—medication review, letter, phone call, extend session

THE ASSESSMENT OF MENTALIZING STYLE

Yet another level of assessing mentalizing capacity to consider is mentalizing style (hypermentalizing, hypomentalizing, no mentalizing, accurate mentalizing). As originally described by Dziobek (Dziobek et al., 2006), hypermentalizing (or excessive ToM) refers to an overattribution of mental states, as opposed to hypomentalizing, which refers to low and inadequate use of mental states. No mentalizing refers to no use of mental states. To illustrate, let's imagine a situation where someone does not turn up for a prearranged dinner with a friend. If we ask the person why she thinks her friend did not turn up, we might get the following responses:

It is often after a therapist's temporary loss of mentalizing that significant progress is made.

- "I just knew she would not turn up! It's because of that time—gosh—it's probably 3 years ago that I stood her up and I bet she is now punishing me for that—just at a time that she knows I need her. She waited for just the right moment to show me who is boss." (hypermentalizing)
- "There was traffic." (no mentalizing)
- "I was late, so she left." (undermentalizing/hypomentalizing)

There is some overlap between the nonmentalizing modes and the various mentalizing styles. Often, when a person is in psychic equivalence, she may also be hypermentalizing. This is because when in psychic equivalence, a person is *certain* that what is in her mind reflects reality, and in the case of hypermentalizing, that reality is what is attributed to someone else's mind. The example in Box 4.1 (Gina) provided good examples of hypermentalizing statements (e.g., "I don't want to pause anything, I know what you are up to, you want to blame me, tell me it is my own fault, that I have to work with myself, that we should try and look at it together [makes a face] . . . no way, you obviously don't want to help me, that is clear . . . you just want to talk, I need action, action . . . Lisa doesn't like me, I know for a fact, and Carl ignores me on purpose"). It is clear that hypermentalizing denotes a particular form of psychic equivalence—in particular, certainty about what is in the mind of someone else. Our research described earlier has shown hypermentalizing to be one of the most common mentalizing errors that individuals with BPD engage in (Penner et al., 2020; Sharp et al., 2011). Our research has also shown that if hypermentalizing reduces over the course of treatment, borderline symptoms also reduce (Sharp et al., 2013). In contrast to a person in psychic equivalence who may be hypermentalizing, someone in pretend mode may not be reflecting on her thoughts and feelings and may be engaged in no mentalizing or hypomentalizing, hence the disconnect between affect and cognition. Someone in teleological mode is also not making use of mental states to explain actions of self or other, but instead relies on concrete or physically observable behaviors or objects—again, mostly in a state of no mentalizing or hypomentalizing.

THE ASSESSMENT OF THE MENTALIZING POLARITIES

In Chapter 2, various mentalizing polarities were described (self/other; cognitive/affective; automatic-implicit/controlled-explicit; and internal/external). We emphasized that good mentalizing implies that a person can *hold the balance* between these polarities depending on the context. Recall our wife/husband and burglar examples from Chapter 2. When your spouse drops the ball on something he was supposed to do for you, more reflective, cognitive, and controlled mentalizing may get you further than implicit and affective mentalizing. In contrast, when you encounter a burglar in your living room, automatic-implicit

and affective mentalizing is likely the more optimal way to go. It is important for the therapist to assess the predominant polarity that a person may be mentalizing from, keeping in mind that no polarity in and of itself is maladaptive. Instead, the therapist is assessing the fit between the mentalizing polarity and the context, content, and style of what is being discussed. For instance, a person talking about abuse or rape in an intellectualized way may be said to be engaged in overly cognitive mentalizing (she is likely in pretend mode, defending against the painful impact of the rape). Being unable to stop crying, or raging against someone or something to the point of not being comprehensible to the therapist, is considered overly affective mentalizing, and so on.

Here it may be helpful to point out that the same context-dependent quality needs to be assessed and borne in mind in terms of how we evaluate the nonmentalizing modes. In other words, there are certain contexts when nonmentalizing states of mind are actually perfectly adapted for the context. Teleology is easy to explain in this regard: when we are hungry we solve this distress through teleology—we eat. Likewise, when a small child tries to run into the road, we grab her. Equally, though, when she puts her hand toward a flame we yell, “Stop! You’ll burn yourself!” with no doubt about the equivalence between the thought in our mind (“Fire injures!”) and the reality of the world out there—our voices expressing something of the urgency in such a lesson. When we’re discussing our child’s fascination with flames later in private with our partner, over a glass of wine, we might get rather carried away with the many possible ways to make sense of this quirk, but in so doing (perhaps both musing on our own childhood memories of fire) we may stumble on something of value that offers us a window onto how we might try to address this with neither overreaction nor under reaction. In the moment of peril, though, this reflective mentalizing would be counterproductive and will not protect our child from the flame.

No polarity in and of itself is maladaptive.

KEY SUMMARY POINTS TO REMEMBER WHEN ASSESSING MENTALIZING

1. Most important when assessing mentalizing is the assessment of overall mentalizing breakdown. While the assessment of particular

mentalizing styles, modes, or polarities is helpful in planning mentalizing interventions (Chapter 6), it is most important that the therapist become aware that a break in mentalizing had occurred. Thus, getting a broad sense of whether someone is currently mentalizing or not is the most important type of assessment that takes place.

2. To construct a mentalizing profile (see next section), the assessment of all aspects of mentalizing (style, mode, and polarity) may be helpful, but it is not essential that all of these be assessed. Clients may show predominant mentalizing styles, polarities, or modes, and may also shift between them. Therapists should not get bogged down with feeling that they have to assess all of these in a precise way.

3. In assessing mentalizing, it is also important for the therapist to assess which topics or content might be associated with switches between polarities. It may be, for instance, that a client tends to begin intellectualizing (cognitive mentalizing) whenever a particular topic comes up. Or there may be a certain person or event that pushes a client's buttons to shut down reflective controlled mentalizing and flips them into a state of automatic-implicit mentalizing. During the assessment period, it is appropriate, and even important, to probe and challenge the client to test the limits of her ability to stay in a Mentalizing Stance when speaking about particular attachment figures, events or concerns. Probing can occur by asking questions such as "Why do you think she did that?" "If your mom were in the room, what do you think she'd say about that?" "That's tough—how did you manage that?" "What do you think she was feeling when that happened?" "Did it make sense to you that you did that?" "I'm not quite following—how did her behavior lead to you walking out the room?" "Can you expand on that—what was the impact of her behavior on you?" Gross imbalances across more than one attachment figure or context are important to note, as are imbalances that are more specific to particular attachment relationships or contexts. For instance, a person may have particular mentalizing vulnerabilities in the work context that she doesn't have in the home context.

4. The assessment of mentalizing in the context of the new attachment relationship (the relationship with you as therapist) is also important. Does the client take your mental states into account as she shares events, memories, thoughts, and feelings with you (good

mentalizing)? Does the client attribute mental states to you or make assumptions about what you might be thinking (hypermentalizing)? Is the client overly certain about the effect of her words on you (psychic equivalence)? Does the client provide enough context for you to understand what she is trying to convey (good mentalizing)? In many ways, the therapy context provides an excellent context for the assessment of mentalizing precisely because of the vulnerability involved in sharing painful content with a stranger whom one is "supposed" to trust if the helping relationship is to have a chance of working. Thus, the therapeutic context provides a good litmus test for limits in epistemic trust and how these limits may impede an individual's capacity to mentalize when talking about emotionally arousing content.

5. Most therapists will be assessing mentalizing in an unstructured way as described above. However, there are a host of mentalizing measures that are typically used in research that can be used in the clinical context as well. In our adolescent clinic at the University of Houston, we readily use the Movie Assessment for Social Cognition (MASC; Dziobek et al., 2006) as well as the Reflective Function Questionnaire for Youth (RFQY; Ha, Sharp, Ensink, Fonagy, & Cirino, 2013). For a comprehensive list of measures that may be considered for more structured assessment of mentalizing, Luyten and colleagues (2019) can be consulted.

THE MENTALIZING PROFILE

The assessment of the various aspects of mentalizing takes one to two sessions. A third session can be added if needed. We reiterate that the assessment of mentalizing provides the frame for the assessment that usually occurs in the first one to three sessions with a new client. In common with ordinary clinical practice, the client's history and current mental state are assessed, but in discussing this content, the therapist is also busy making an assessment of the client's mentalizing capacity so that this assessment can guide the model-specific clinical formulation. The first step toward the clinical formulation is articulating the mentalizing profile of the client. Doing so is important because empirical research (see Figure 4.1, Chapter 4; Gambin et al., 2015) and clinical experience (Luyten et al., 2019) demonstrate

that certain classes of disorders or personality pathology types tend to be associated with particular mentalizing profiles. Luyten and colleagues (2019) produced the graph in Figure 5.1, which depicts the various mentalizing profiles associated with different types of personality pathology using the mentalizing polarities.

To make this clinically relevant, we have produced a fictive mentalizing profile for the typical borderline client as represented in Figure 5.1. This kind of mentalizing profile can be incorporated into the mentalizing formulation of the client at the conclusion of the assessment phase. It should be shared with and explained to the client in ways that allow for exploration and a shared understanding, and this should also be communicated during MBT supervision to the MBT supervisor. In talking to patients to build a

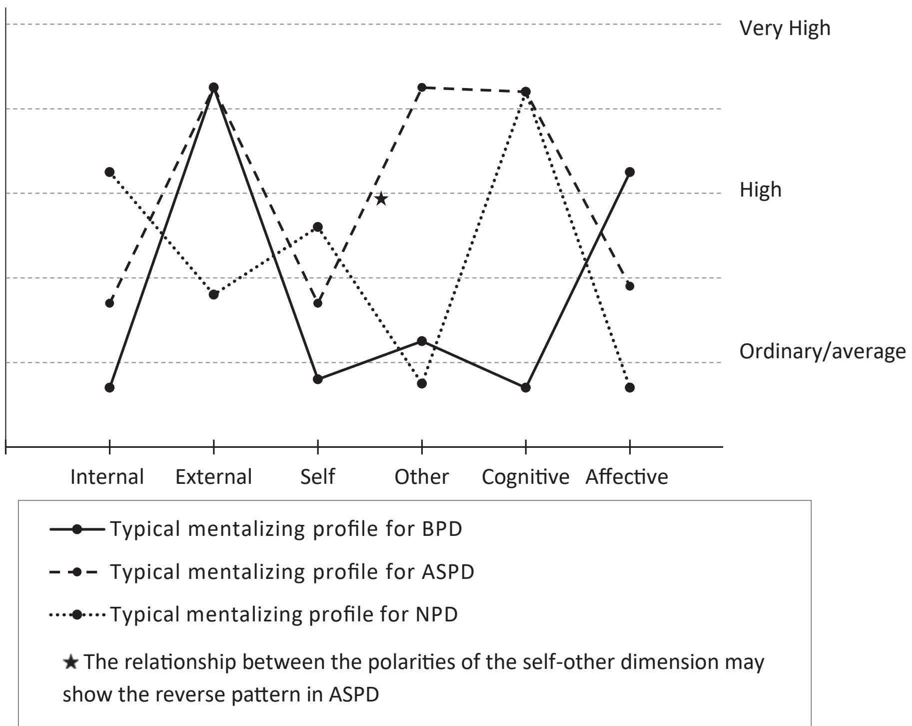


FIGURE 5.1. Various mentalizing profiles associated with different types of personality pathology using the mentalizing polarities. Reprinted with permission from Luyten, Malcorps, Fonagy, and Ensink (2019).

co-constructed formulation, it is important to hold in mind that this is almost always a highly exposing situation for a patient, and so her capacity to mentalize us in our role at this time may be reduced. It is easy at this point for well-intentioned efforts at clarity and accuracy on our part to be experienced as judgmental or even deliberately cruel. For this reason, taking time to broadcast our own intentions (in order to aid the client's mentalizing of us) and to explain and frame our explanations in ways that are understandable, transparent, and benign is essential. Without this reciprocal process there is a risk that our formulation will be received as (perhaps yet another) instance of our client being "done unto" rather than "doing with." On paper, a mentalizing profile stripped of this context and understanding checking could be read as bleak or critical. The example profile given in Box 5.2 consists of the facts as the therapist might understand them but would need richer explanation and contextualization if shared with the client. In other words, what follows is a representation of a representation of reality (in this case fictional), and the extent to which this status is borne in mind is the extent to which we as authors and readers can maintain a Mentalizing Stance toward it. So go gently!

Box 5.2. Mrs. Z's Mentalizing Profile

Mrs. Z's mentalizing profile is characterized by a relative lack of focus on the internal mental states in herself and others that may help explain behaviors, thoughts, and feelings. Instead, she appears to be overly concerned with what can readily be observed in others, believing that unless there is concrete evidence of another person's feelings toward her, those feelings do not exist. Consistent with the lack of use of internal mental states to make sense of her interpersonal life, Mrs. Z's mentalizing profile is characterized by a lack of focus on self and others' mental states. She appears to engage in little reflection on her own mental states and how these may connect, affect, or be affected by the mental states of others. Consequently, little negotiation takes place with others to arrive at a shared understanding of the different perspectives others may hold in relation to her own perspectives. She tends to jump to conclusions and is often in a state of psychic equivalence. This lack of reflection is also apparent in a reduced use of explicit-controlled mentalizing in favor of more automatic and affective mentalizing. These imbalances are most

striking when Mrs. Z talks about the relationship with her husband. At times, when discussing her relationship with her husband, it became hard to follow what Mrs. Z was trying to communicate, and when asked to clarify certain aspects, she thought that the therapist was trying to undermine her attempt at communicating by asking too many questions, signaling a tendency to hypermentalize. Mrs. Z was able to recover relatively well once the therapist explained that a lot of information was being shared and that she needed time to catch up, suggesting that Mrs. Z has the capacity to switch into a more reflective state of mentalizing when provided the right scaffolding to do so.

THE MENTALIZING FORMULATION

The mentalizing formulation makes use of all the information gathered in the client's history, mental state exam, and mentalizing profile and integrates it into a mentalization-based formulation. Because it is mentalization based, the formulation is necessarily also attachment based or relational, because as we discussed in Chapter 2, mentalizing develops and "lives" in the attachment context. The mentalizing formulation may be communicated verbally to the client during the next session. Following on from our comments about the mentalizing profile above, it is important that the formulation be presented in ways that frame it as a preliminary working hypothesis of how the client's presenting problems and history may impact her capacity to mentalize, and the effect that the resulting breakdown in mentalizing may have in maintaining the client's problems. The *preliminary* nature of this "first attempt" is crucial to communicate because implicit in this is an invitation and encouragement. During the course of the sessions ahead it is expected that this account will be adjusted, corrected, enriched, and improved through the joint efforts of therapist and patient. In our experience, a letter is often an effective means of communicating the mentalizing formulation, and in many cases—assuming the therapist has gotten her mentalizing accurate enough—is reportedly treasured. The important thing is that such a communication conveys authenticity and enthusiasm to learn on the part of the therapist (as opposed to a kind of psychic equivalent certainty dressed up as expertise). For clients with literacy problems, recorded speech or a short video might aid accessibility, and therapists may want to remember to ask about what medium would work best for a patient.

Box 5.3 provides a brief example of such communication to an 18-year-old female client with BPD. Notice that the therapist tries to link the presenting problems (suicide attempt, drug abuse, emotion dysregulation, experiential avoidance) to mentalizing impairment (in this case mentalizing the self). Also notice that the therapist readily shares with the client the effect that the information has on the therapist herself, thereby embodying the transparency of the Mentalizing Stance (see Chapter 6) and the relational nature of this approach from the outset. In MBT we say that *we put our mind on the table*—simply meaning that we share the content of our mind with our clients, thereby modeling the Mentalizing Stance. A constrained degree of self-disclosure in this sense is therefore not only allowed, but encouraged in MBT. To summarize some of the points in the preceding paragraphs, the formulation is communicated in a collaborative way that signals the fact that meaning will be created collaboratively. Finally, the formulation is communicated in tentative terms so that, from the outset, the mentalizing context of uncertainty is emphasized along with an expectation of improved understanding through reciprocal exchanges.

Share the mentalization-based formulation as a preliminary working hypothesis.

Box 5.3. Written Formulation for MJ

Dear MJ,

We have seen each other now for two sessions, and you have provided me with very important information to begin thinking about how everything might fit together for you. These are just initial impressions of mine that might still change, but I want to run my impressions by you and put my cards on the table, if that is okay? I want to see if I got things right and whether what I'm thinking could be a good starting point for our work together.

During our first session, I was struck by how much you have been through even though you are just 18 years old. You were adopted when you were a baby; then your adopted parents divorced when you were 6. It sounds like you witnessed quite a lot of abuse from your father toward your mother, which was very scary for you. You lost contact with your father soon after your parents' divorce. You told me your problems started in middle school because you felt you did not fit in, and you were also struggling academically. You started using alcohol in middle school,

and soon after that you started smoking weed. Weed has become a big part of your life, and you say it helps with your anxiety. You smoke when you wake up and whenever things get too much for you. Things were okay for you for a while, even though you dropped out of school last year at age 17, but then things came to a head for you when your boyfriend was sent to prison about a month ago. You told me your boyfriend is the only person in your life who "gets" you and for whom you do not have to pretend. I felt moved when you described to me what it feels like when he holds your hand—that you feel completely safe with him. You feel your mom loves you, but you don't want to burden her with your problems. So when your boyfriend got sent to jail you felt alone and isolated and you made a suicide attempt. You told me you feel you cannot live without him. You are not allowed to visit him, and this thought fills you with incredible panic.

When I asked you what you would like to gain in therapy you said you want to be able to get through the time waiting for your boyfriend to get out of jail without killing yourself. I think I understand that. The impression I got from listening to you is that you have many strong feelings that get unbearable and the only way to tolerate them is by smoking or by hurting yourself. It sounds to me as if it is often way too painful for you to experience some of these emotions and therefore you kind of try and avoid them altogether. The kind of therapy that I do, called mentalization-based therapy, helps people to look at their feelings more closely and to slow down to try and manage those feelings. So I think I can help you. It is going to be hard work, but I am up for it and I want to find out whether you want to give it try.

I have plenty of expertise in what I do, but you have all the expertise in what it is to be you. I want you to know that I will be trying to learn from you so that you can see things beginning to make more sense in my mind. When you can look at me and say, "You are beginning to understand things how I see them," then it is likely that we can work on how to make changes that make sense and feel helpful to you. Just to warn you: I won't always get it right the first time, even though I want to. You need to feel confident that telling me I have missed something is always helpful to me, and I think it is usually helpful for my patients too; being misunderstood by people (or misunderstanding them) is common indeed, so understanding how this happens so that it happens less is a lot of what we will try to do together. I look forward to getting started.

In MBT for Adolescents (MBT-A) as adapted by Trudie Rossouw, the formulation is written and given to the adolescent client and her family. This is actually good practice also for adult clients.

Clients feel overwhelmed emotionally when they begin therapeutic work, and while they may *listen* to the formulation when you share it to them verbally, they may not *hear* it. Having something on paper to share with them forms an important foundation to return to throughout the therapy process. Of course, to reiterate, it is important that they know the formulation can (and almost certainly will) be corrected and expanded as new information comes to light.

CHAPTER SUMMARY

Our goal in this chapter was to provide you with the tools for the assessment of mentalizing. Knowing how to assess mentalizing is of critical importance because as you will learn in the chapters that follow, the success of the MBT therapist relies heavily on the capacity of the therapist to notice when there is a breakdown in mentalizing capacity. Therefore, the continuous assessment of the client's mentalizing capacity as well as the therapist's own mentalizing capacity throughout sessions and treatment form the cornerstone of MBT. In this chapter we discussed the assessment of several aspects of mentalizing: overall mentalizing capacity, prementalizing modes, mentalizing style, and mentalizing polarities. We discussed how the assessments of mentalizing early on in the work with a client inform the development of a client-specific mentalizing profile and, ultimately, the mentalizing formulation, which integrates all aspects of the client's history and presenting problems but frames them in terms of mentalizing capacity. The collaborative and tentative nature of the mentalizing formulation is underscored as the first opportunity for the therapist to signal to the client what mentalizing is all about. We are finally ready to move on to mentalizing interventions. We begin by introducing the MBT structure in Chapter 6.

CHAPTER 6

MBT Structure

As articulated in Chapter 1, the aim of this book is to provide a foundation that can position you to develop expertise in MBT or other mentalization-based approaches to therapy. Actually, we hope what we write might enrich the therapeutic work of those who labor with other treatment models, too. As we have seen so far, much of what mentalizing entails falls under the rubric of the "common factors" that underpin all evidence-based effective psychotherapeutic work. In this chapter we provide you with a few core essentials about the structure of MBT. Understanding those essentials may help you assess whether you want to take a deeper dive into MBT, MBT-A, MBT-F (Mentalization-Based Treatment for Families), AMBIT (Adolescent Mentalization-Based Integrative Treatment), or any of the many different ways mentalizing has been used to shape helping methods and techniques.

There are already excellent books and manuals that describe MBT in detail (e.g., Bateman & Fonagy, 2016); what we want to provide you with, above all, is a sense of what lies at the heart of the mentalizing approaches, and that is the Mentalizing Stance. In this chapter and the chapters that follow, we will bring all this theory and research together in a practical way to help you get a sense of what it is to feel both in and out of balance (for what else is a *stance* but that?).

Up to this point, we hope you will have gained a fairly good understanding of what shared meanings are conjured by the term *mentalizing,* especially among the many people who have developed and conducted the science that underpins its use in therapeutic work. Thus you will know, by now, that mentalizing refers to an imaginative process of reflection that is directed at creating coherent narratives to make sense of behavior on the basis of the minds that underlie that behavior. You know, further, that in this reflective process, we recognize that the mind constructs versions of reality, and that in order to get on with people, we need to understand how we got to our own unique representations of reality, how those representations differ from the representations others have formed, and how our differing representations may be impacting upon our own feelings and actions, and upon those around us.

In the sections that follow we present how this Mentalizing Stance might feel, might be recognizable, and might play out in the kinds of interactions that occur with other minds that we encounter in our work (and outside of our work, too). We hope from this you will gain a familiarity not just with the intellectual building blocks that underpin mentalizing, but also with the emotional and situational awareness of this most evanescent and fleeting state of mind.

It would be no less futile for a master martial artist to write instructions on how to hold one's fighting stance and expect his followers to achieve this without practice than it would be for us to write about the Mentalizing Stance and expect that to be sufficient for you to become competent with it. We are certainly not master mentalizers. In fact, perhaps strength in mentalizing comes precisely in the recognition of its fragility, along with the capacity to disconnect some of the (inevitable) experiences of loss of balance from feelings of shame or professional inadequacy. The idea of mentalizing as an individual "ninja skill" or "warrior strength" is a dangerous fantasy—one might call it a sentimentalizing heresy that denies the social and relational roots of mentalizing.

Most of our clients come into the consultation room with a crisis or dilemma that has locked them into rigid, perhaps singular, ways of seeing themselves, others, or their situations. They usually feel certain in their views and cannot imagine any alternative. In this sense they are likely caught in a state of psychic equivalence and will flip between teleological solutions to their problems or pretend

mode (that they are unaware of) for managing the difficult emotions associated with it. Our job as mentalizing therapists (regardless of our orientation) is to help clients free themselves from this rigid inflexibility so that they can imagine (and live) alternatives again. Thus, the primary goal is to help the patient move toward and better sustain alertness to his own mental processes and focus somewhat more on how he and others are thinking and feeling at any given moment. In that effort our clients will become more mindful of the minds that are at play, and better able to suspend certainty so that they can experience the relief from being trapped in their fixed beliefs and perhaps to explore new ways forward. In so doing, they become *agentic,* because they *actively make choices in accordance with their values.*

We have given you the "what" and "why" of a mentalization-based approach to therapy in the preceding chapters. The goal of this chapter and the next is to give you the "how." First we introduce the basic structure and trajectory of MBT, as well as an attempt to define the Mentalizing Stance in more descriptive detail. Chapter 7 will address specific mentalizing interventions that work *through* such a stance, and give examples of how the stance flexes to support such purposeful interactions. In this chapter and the next, we will make use of one case (MJ) to illustrate our points. This client is the same 18-year-old young person we wrote the MBT formulation for in Chapter 5 (see Box 5.3), so she is already a bit familiar to you. We hope that by using the same case, we are able to increase coherence in understanding the MBT treatment trajectory, process, and interventions.

> *Our job is to help clients free themselves from inflexibility.*

The Case of MJ

MJ is an 18-year-old White female, and was referred for psychotherapy by her psychiatrist. MJ has recently been diagnosed with BPD, major depression, and substance use disorder (marijuana). She was discharged the previous week from the hospital after a suicide attempt. She is currently living with her mother. MJ was adopted at birth. She has a younger brother of 16, who was also adopted but is not biologically related to her. Her adoptive parents divorced when

MJ was 6 years old. Since then she has been estranged from her father and has no contact with him. MJ attends the first session with her mother, who has brought her to therapy. When walking from the waiting room to the consultation room with her, you notice that MJ is limping. When you comment on the limp, she explains that she had cut herself so deeply on her thigh that it is hard to bend her leg due to the stitches.

While MJ calls herself by this abbreviation, you learn that her actual name is Anna, and her mother calls her by the name Anna. During the first session, which starts off with both MJ and her mother, MJ's mother provides most of the history and emphasizes that unless MJ gets help now, it is not clear what the future holds for her. MJ dropped out of high school the year before without graduating. She was recently asked to leave her job at an ice-cream parlor because of frequent absences. Her mother tolerates her substance use because she says that it is the only way that MJ knows how to cope; however, she also feels that the smoking contributes to MJ's lethargy and wishes that she would stop. When asked what brought her to therapy, MJ at first remains silent, and after the therapist comments that it is hard to talk to a stranger, she says that she feels depressed because her boyfriend is in jail. She says she cannot live without him and therefore wants to kill herself. She believes he is the only person that "gets" her and that she does not feel safe with anyone else. She was going to marry him, but now all of that seems impossible because she believes that he will forget about her while they are separated. When asked how long she and her boyfriend had been together, MJ reveals that it had been a 3-month relationship when he was arrested. At this point, she breaks down in tears.

STRUCTURE AND TRAJECTORY OF TREATMENT

Broadly speaking, mentalization-based therapies have three phases: Beginning, Middle, and End. For ease of communication, and because MBT was originally developed in the context of BPD, we again use BPD as an example disorder in presenting the material below. In Chapter 5, we emphasized that treatment begins with the assessment phase, which lasts one to three sessions, culminating in the formulation. In addition to assessment, the Beginning phase also includes

discussing the diagnosis, providing psychoeducation, establishing a hierarchy of therapeutic aims, defining a crisis pathway and agreeing on outcome monitoring. While assessment may last one to three sessions, other introductory aspects may add another one to two sessions, which means that the Middle phase may start around four to five sessions into the relationship with a client. The Middle phase of treatment, which lasts the longest, consists of the active therapeutic work aimed at stimulating more robust mentalizing. Table 6.1 synthesizes the goal and nature of each of the steps in the trajectory of treatment.

Let us now see how we might present aspects of the Beginning phase to MJ. We expand on the initial mentalizing formulation that we presented in Chapter 5, to also include a crisis plan and risk assessment, contracting around potential treatment interfering behaviors and monitoring of outcomes. Throughout the written formulation presented below in Box 6.1, we have **bolded** words that "mark" mentalizing. In other words, from the get-go, in MBT, we are making explicit when we or the client are mentalizing. In mentalizing language we refer to this as "marking," or "ostensive cueing," which we discussed in Chapter 3. Put differently, we try to highlight or draw attention to when we think mentalizing is happening. Thus, it is already possible and desirable to begin the process of highlighting existing efforts and successes in mentalizing by the client. In so doing, the therapist is using such moments as *in vivo* (living, real-time) opportunities for several things: first, for broadcasting and explaining the framework that will be useful for understanding what lies beneath the fact that things are often so difficult (psychoeducation about the challenge of sustaining accurate mentalizing under pressure); second, for pointing out what is already present that can be built upon (mentalizing efforts by the patient that are spotted in spite this challenge—and there will be examples, if we care to look); and third, beginning to lay out what the focus and shape of the work ahead will look like (more or less structured and methodical efforts to help build on and around this capacity of mentalizing).

This sharing and marking of mentalizing is essential throughout therapy; it could be described as consistently putting our mind (the equivalent of our "cards") on the table—and is maintained in all communication, verbal and written, with clients. This is important, because it introduces "thinking language" (cognitive and

TABLE 6.1. The Structure of Mentalization-Based Intervention

	Trajectory of Treatment	
BEGINNING	Assessment *Sessions 1–3* *Month 1*	• See Chapter 5 for more detail on how to assess mentalizing. • The goal is to arrive at a mentalizing profile and formulation that is shared with the client.
	Diagnosis and psychoeducation *Sessions 4–5* *Months 1–2*	• We do not shy away from talking about a personality disorder diagnosis as to do so would risk perpetuating the existing stigma against personality disorder. • With the above in mind, it is often helpful to use the DSM-5 Section III (Criterion A) formulation of BPD or ICD-11 severity criterion (maladaptive self and interpersonal function) rather than any particular personality disorder. Some clients and workers will prefer to use a categorical diagnosis (like BPD) if they are more familiar with that. The advantage of using Criterion A is that you can express the diagnosis in relational terms, which is consistent with MBT, for example, "Personality disorder refers to problems in how you manage yourself and your relationships" or for adolescence, "You are busy building your personality, and from what you said, it sounds like you are struggling with the process of putting together all the pieces of who you are as a person." • Communicate that personality challenges or relational patterns *are not intractable*. They change naturally over time, regardless of being in therapy or not. In addition, they can be positively impacted with treatment. Emphasize therefore that personality challenges are just like depression and anxiety. They come and go and are susceptible to intervention. In adolescence: "This is exactly the right time to intervene, because your personality is still very plastic; it can still change a lot and I'm very glad we can look at your personality development together at this point in time." • Most importantly, your aim in communicating diagnosis is to engage the client in a dialogue about his experience (e.g., "Does this ring true?" "Have you heard the term BPD before?" "What do you think about it?" "What does it mean to have been given such a diagnosis?").
	Formulation *Sessions 4–5* *Months 1–2*	In Chapter 5 we provided an initial formulation written in mentalizing terms. Several additional aspects, shown below, can be included in the formulation. • Crisis plan and risk assessment: The formulation includes reference to risk management for clients who have a history of self-injurious behavior and/or who are suicidal at the time of assessment.

(*continued*)

TABLE 6.1. (*continued*)

	Trajectory of Treatment	
		• Contracting regarding barriers to treatment: The formulation may include reference to treatment-interfering behaviors such as substance use (e.g., "I will need you to be mentally present during our sessions, so our sessions won't work if you are high"). • Agreement to outcome monitoring: The formulation may include reference to treatment monitoring through a brief weekly survey of symptoms.
	Introduction to the MBT model *Sessions 4–5* *Months 1–2*	• The therapist uses the formulation to point out instances where the client was able to understand or make sense of what was happening to him. • These are then used to explain what MBT is—that MBT is focused on being able to understand what happens even when one is upset, hurt, or angry, and on slowing down and making sense of others and ourselves in the context of our relationships and the things that happen to us.
MIDDLE	MBT individual and group sessions *Months 2–12*	• There are now many variants of MBT, but most MBT programs for personality disorder will require at least 12 months of weekly 50-minute individual sessions in combination with 75-minute group (adults) or family (adolescents) sessions. • For more detail on variants of this basic structure, consult the Bateman and Fonagy (2016) manual. To fully adhere to the model, it is important that the evidence-based structure be maintained. However, in real-life situations (and with expansion to other populations) the basic MBT structure that has been proven effective for adult BPD may be varied. • The middle phase constitutes the active therapeutic work and includes the mentalizing interventions that we will discuss in more detail in Chapter 7.
END	End *Months 12–18*	• The final phase starts at the 12-month point and takes another 6 months because it is focused on consolidation of gains and negotiation and processing of separation. • MBT is a relational psychotherapy. The therapist must never underestimate the profound impact that the psychotherapy relationship has on a client. The termination process is therefore handled collaboratively with the client.

explicit-controlled mentalizing—see Chapter 2), alongside the uncertainty that this embraces, into a narrative; this, for most clients, may be quite a new way of approaching the world, themselves and their problems. It introduces the notion of "thinking about thinking" (a phrase that refers to *meta-cognition*), showing the client that we pause to evaluate the *way* we are thinking as much as—perhaps more than—we simply follow the content of our thoughts. It also brings critical transparency to the therapeutic process, which is important when working especially with clients who suffer from severe epistemic mistrust. Beyond these explicit-controlled mentalizing introjections, notice also the affective mentalizing that the therapist has dispersed throughout the formulation. These affective components of mentalizing are important because, done well, they can help to validate the client's subjective experience. As mentalizing therapists, we constantly ask ourselves, what does it feel like to be in the skin of our client? Of course, we can never really know. Rather, it is in the act of asking and the effort of imagining, and the humility of being able to reformulate our earlier inaccurate guesses in front of our clients, that the magic of mentalizing happens.

Marking of mentalizing is essential throughout therapy.

For ease and the purpose of demonstration in Box 6.1, we have italicized affective statements so that they can be distinguished from the more cognitive and explicit-controlled mentalizing statements, which are presented in bold.

Box 6.1. Written Formulation for MJ

Dear MJ,

We have seen each other now for two sessions and you have provided me with *very important* information **to begin thinking about** how everything might fit together for you. These are just **initial impressions that might still change,** but I want to **run my impressions by you** if that is okay? I **want to see if I got things right** and **whether what I'm thinking could be a good starting point** for our work together. Is that okay?

During our first session, I **was struck** by *how much you have been through* even though you are just 18 years old. You were adopted when you were a baby; then your adopted parents divorced when you were

6. **It sounds like** you witnessed quite a lot of abuse from your father directed at your mother *which was very scary for you*. You lost contact with your father soon after. You told me that your problems started in middle school because you felt that you did not fit in and you were also struggling academically. You started using alcohol in middle school, and soon after that you started smoking dope. Dope **has become a big part of your life,** and you say **it helps with your anxiety**. You smoke when you wake up and whenever things get too much for you. Things were okay for you for a while even though you dropped out of school last year, but then things came to a head for you when your boyfriend was sent to prison about a month ago. You told me that your boyfriend is the only person in your life who "gets" you and for whom you do not have to pretend. *I felt very moved* when you described to me what it feels like when he holds your hand—that *you feel completely safe with him*. You feel that your mom loves you but **you don't want to burden her with your problems**. So when your boyfriend got sent to jail *you felt very alone* and isolated and you made a suicide attempt. You told me that *you feel that you cannot live without him*. You are not allowed to visit him and *this thought fills you with incredible panic*.

When I asked you what you would like to gain in therapy you said that you want to be able to get through the time waiting for your boyfriend to get out of jail without killing yourself. **I think I can understand that, or at least I really want to come to understand it in a way that you feel fits with your experience. The impression I got** from listening to you is that you have many strong *feelings that can get unbearable* and when that happens **the only way to tolerate them** is by smoking or by hurting yourself. **It sounded to me** as if perhaps it is way **too painful for you to experience** some of these emotions and therefore you rather **try to avoid** them altogether. The kind of therapy that I do, called mentalization-based therapy, helps people to **look at their thoughts and feelings more closely and to slow them down to try and manage things**. This kind of therapy also helps us to **make sense of the impact** our relationships have on us, and **how we impact** our relationships. *You have shown great courage* in **understanding the impact** that your boyfriend's departure has on your feelings of aloneness. In mentalization-based therapy, we build on that and **try to make sense of how everything is connected** to *help make you feel stronger* and **better able to cope, especially at those times when feelings are powerful**. So I think I can help you. *It is going to be hard work,* but I am up for it and **I want to find out whether you want to give it a try.**

We have to agree that you will stay alive while we work and that you come to our sessions sober. *I commit* to being here and *being with*

you, and I hope that you will commit to that too by being here and being sober for our sessions. To stay alive, you will have to agree that you will go to the ER or tell your mom if you feel like you want to take your life. **Without that agreement, there is a risk** that my mind's "bandwidth" will be used up in thinking about your safety rather than about the deeper problems that threaten it, where I can (I hope) be most useful. **I am eager to hear what you think about that** and **whether you think you can do that. If you think this will work** for you, we will see each other once a week for 50 minutes alone. Every week, I will give you a short questionnaire that will ask you about that week's symptoms. This is to monitor how you are feeling and for us both to track how you are doing.

I am very excited about working with you. I was very touched by your courage and by how deeply you feel things, and I hope that we *get this chance to work together* to *get to know each other better*.

As indicated in the above formulation, the therapist invites the client to reflect on these initial impressions. In some situations this invitation can be made with a bit of self-deprecating humor makings the point that the therapist is not a mind reader (that position is, of course, the opposite of mentalizing; it is a form of psychic equivalence): "So now I invite you to get your red pen out and mark my homework! The more red ink, the more I can start to work out how I've perhaps misunderstood you in this first effort—so I make sure I don't misunderstand you in the same way again. I hope that doesn't make me sound like a bad therapist, but a realistic one, who's eager to work with you." The formulation can then be amended based on the client's feedback.

Transparency is crucial when working with clients suffering from extreme epistemic mistrust.

MORE ON PSYCHOEDUCATION

The Mentalizing Stance represents the vital ingredient for effecting change in your client. Before we delve deeper into the Mentalizing Stance itself (Chapter 7), we pause to expand on some of the other elements discussed in Table 6.1 as they relate to psychoeducation and

presenting the MBT treatment frame. We also talk about the end phase of a mentalizing intervention.

As described earlier, from the start of therapy, the therapist calls out (draws attention to, or marks) mentalizing when it happens to demonstrate to the client that he already has the skill of mentalizing. The goal of therapy, then, is to expand on these existing skills. In offering psychoeducation to the client, the therapist explains that for all of us, the capacity for mentalizing comes and goes, often in inverse relation to stress. This stage in the course of therapy is also an opportunity for the therapist to emphasize that even professionals are not always great at mentalizing; that misunderstanding each other is what humans do best, but that ideally we collaborate to recognize this and come to understand how and why we misunderstood. The importance of making this attitude explicit is that it allows the patient's expectations of his therapist to be modified: "I can promise you that I will misunderstand you, not because I want to, or will try to, but just because I am human. I want to be as clear as possible that you can feel confident to tell me if you think I have misunderstood, so we can figure out how, and make sure I don't misunderstand you in the same way twice." What is being set up is a frame that explicitly marks out how MBT is not a stage for sages (or authorities—see Chapter 1); it is more a setting where (using a phrase from Shakespeare) the "comedy of errors" (what it is to live in a world of human relationships) can be safely explored, and thereby come to be withstood, even enjoyed.

Some MBT programs offer a much more explicit and formal psychoeducational component as part of their introduction, rather than the forms of in-session, *in vivo* learning that we have described. In such sessions there may even be space for patients to sit in rows in front of a whiteboard or a slide projector. We have found the whiteboard to be especially helpful for adolescents. Now, for patients whose own personal histories of learning and study have been broadly positive, a formal education format might work well, although it is always important to avoid allowing the discussion to slip into a kind of pretend mode in which everyone engages avidly in the theory and language while neatly avoiding their own suffering and the "stuckness" that has brought them to therapy in the first place. On the other hand, many patients will inevitably have many more negative memories and associations with formal learning situations. Sitting

them in front of an "expert" (especially one who uses language that could sound to many skeptical ears dangerously like psychobabble) risks creating exactly the kind of power relationship and context that would inhibit true mentalizing. Some consideration of what might work best for your patient is required, therefore. Another word for such consideration is mentalizing, and the method of mentalizing is most effective when it includes reciprocity, and exchange between two minds. It is perfectly possible that *asking* your patient what he thinks might work best for him is a place to start. The passage below captures what you might say in this regard:

> "Many of my patients find it helpful if I try to explain how I will be trying to work with them, and the explanations—'the science' as it were—for working in this way. I tend to do this as we go along, using examples from what comes up in our conversation here, between us. I find that works best, as it keeps it real, and connected to what we are here for. On the other hand, sometimes some patients like to have a bit of . . . I don't know quite how best to describe it—teaching? coaching? . . . on the science behind this way of working. I am happy to do this, but if I do, then I will always try to avoid that becoming something that slips into psychobabble, which might make one or both of us feel clever but actually end up a getting us disconnected from what's going on here, for you in your life, and for me in really trying to connect in ways that help you to feel better understood and to find better ways forward. I wonder if that makes sense to you? I suppose the most important thing is that you always feel able to ask if something I am doing doesn't make sense to you; in fact, just that—'trying to avoid rushing ahead as if we've made sense when we haven't really'—is probably a good way to start explaining what I'll be trying to do!"

THE END PHASE OF A MENTALIZING INTERVENTION

As summarized in Table 6.1, the final phase of an intervention in classic MBT starts at the 12-month point and lasts another 6 months because it is focused on consolidation of gains and negotiation and processing of separation. Recall, however, that each different

mentalizing intervention may manage the End phase of therapy slightly differently. Therefore, there will be many variations to the clinical application of the ending phase between clinicians, with different types of patients, and in different time formats (e.g., short-term or long-term, predefined or open-ended). Whichever format it takes, the ending phase of therapy deserves special attention because mentalization-based therapies are in essence relational. The therapist must never underestimate the profound impact that the psychotherapy relationship has on a client. The termination process is therefore handled collaboratively with the client and should include mentalizing the often complicated and mixed feelings associated with the separation and loss of the therapeutic relationship (Juul, Simonsen, & Bateman, 2020). To unpack this a bit, it is helpful to consider how each of the nonmentalizing modes plays itself out during the termination phase of therapy. In this discussion, we rely on Juul, Simonsen, and Bateman's (2020) helpful elaboration of how to thoughtfully go about the End phase of a mentalizing therapy, and encourage readers to read this paper in more detail.

"The ending phase deserves special attention, because mentalization-based therapies are in essence relational.

Impending termination of therapy may stimulate psychic equivalence in which the client feels that the physical separation from the therapist also implies an emotional separation: "Because I won't be seeing my therapist, it means she does not care for me anymore." This client belief may manifest in teleological behaviors: clinging behavior or requests to postpone termination. The client is struggling to form a mental representation of the therapist once the therapist is no longer physically present and may insist on continued physical contact. Alternatively, or in parallel, pretend mode may dominate a client's management of an impending separation, manifesting in apparent competence or lack of acknowledgment and elaboration of the painful effect that the separation may have. In these states of vulnerability, the epistemic mistrust that originally brought the client into therapy may be reignited, and the client may experience increased vigilance that the therapist's reinforcements of autonomy and validation of good mentalizing are meant to get them "out the door," and may even be seen as signs of masked abandonment.

The mentalizing approach to termination of therapy draws

on the exact interventions that you will learn in Chapters 7 and 8. Instead of glancing over the impending separation, the therapist will use the techniques that we will teach you in Chapters 7 and 8 to *slow down* around the topic of termination and clarify its meaning for the client and its impact on both client and therapist. As always, the therapist will put his mind on the table and invite the client to do the same. In so doing, the therapist and client work through the ending of the relationship in mentalizing terms. In addition, as suggested by Juul, Simonsen, and Bateman (2020), a *termination formulation* can be generated. This formulation is similar to the mentalizing formulation created at the beginning of therapy but serves as a summary of gains made through the therapy, as well as a toolbox that contains strategies to maintain mentalizing capacities outside of the treatment system and prevent relapse.

CHAPTER SUMMARY

In this chapter, our goal was to introduce you to the broad structure of mentalization-based treatments. We used the classic MBT for BPD as an example, and we provided hands-on examples of how to introduce the intervention to your client, how to manage discussions about diagnosis, and how to communicate the mentalizing formulation. We showed that formal MBT consists of Beginning, Middle, and End phases, with the Beginning mostly concerned with assessment, diagnosis, psychoeducation, formulation, risk assessment and management, and the introduction of the MBT model to the client. The Middle phase comprises the active therapy sessions, which are facilitated by the therapist's Mentalizing Stance. Chapters 7 and 8 will walk you through the Mentalizing Stance (Chapter 7) and associated mentalizing interventions (Chapter 8). In this chapter, we emphasized the importance of being explicit in maintaining the Mentalizing Stance specifically through the End phase of therapy and to consider the use of a termination formulation to aid in meaning-making of the End phase as well as planning for relapse prevention. We are now ready to elaborate on the Mentalizing Stance.

CHAPTER 7

The Mentalizing Stance

The goal of MBT is to help the client take the risk of attempting new ways to communicate, cope, and relate, in order to replace a nonmentalizing illusion of control and attachment with a mentalizing approach that offers the opportunity for real mastery and genuine attachments (Bateman & Fonagy, 2012). Let us first unpack this statement a bit.

As articulated earlier, our clients tend to come to us in rather fixed, inflexible states of rigidity and psychic equivalence, where they use teleological solutions to their problems and/or manage their emotions by an unconscious defense against them (pretend mode). For example, MJ arrived at her first session believing that her life was not worth living without the physical presence of her boyfriend (teleological mode). She held a set of assumptions about which she felt certain (psychic equivalence): her boyfriend was the only person who would ever "get" her; she did not (or could not) feel safe with anyone else; she was certain that her boyfriend would forget about her while they were separated. In addition, MJ's expectations about her 3-month relationship with her boyfriend and the intensity of her emotions were not quite making sense from the outside. This leaves the impression of a disconnect between her emotions, thoughts, and the impact of events (pretend mode). When these are taken together, MJ is possibly experiencing a nonmentalizing illusion of control maintained by marijuana use, which dulls her experience of her emotions—most

likely serving a protective function. She is also likely experiencing a nonmentalizing illusion of attachment to her boyfriend, at the cost of being unable to make use of her other attachment relationships. The end result is feelings of desperation to the point of wanting to take her own life.

For MJ, the goal of MBT is to try a new (authentic) way of relating to herself, as well as to others. The path by which this will be achieved, if taking a mentalizing approach, is not principally through looking back into the past (psychoanalytic approaches). It is not principally by gaining insight into thoughts, feelings, or behaviors (psychodynamic approaches). And it is not primarily by changing thoughts (CBT) or her behavior (DBT). In the mentalizing framework, the path through which MJ's goals will be achieved is by changing the serve-and-return (the "ping-pong") between her and others in the here and now. Through mentalizing work, the intention is that the serve-and-return will slow down and will become more reflective. This will give her a sense of agency and choice in her interactions and, as she generalizes this skill, will help her regulate her own behavior and relationships. Therefore, in the mentalizing approach, the pathway to change is through the enhancement of mentalizing. Of course, in so doing, MJ may well gain insight into her past; she will most certainly gain insight into her thoughts, feelings, and behaviors; and she will most likely change her thoughts, feelings, and behaviors. In the end, all the brand-name therapies (arguably) improve outcomes for our clients—they each just take a different route toward achieving those goals. In our view, the mentalizing route is particularly effective because it causes a fundamental shift not only in how problems manifest (thoughts, feelings, and behavior), but in the mental representation of those manifestations. It causes a fundamental shift in a person's sense of how she relates to self and others—her personality function. For many clients, especially those with personality challenges, this is experienced as an incredible gift: the **felt sense of knowing** that they have the tools to live more harmoniously with themselves and others.

This process begins in the therapy room and is later generalized to the outside world. Borrowing from related work (Sharp et al., 2020), we have begun to talk about enhancing the **interaction literacy** in our clients. Through her early experiences of complex attachment relationships, MJ has not achieved adequate literacy of interaction. For good reasons, the laboratory for practicing the serve-and-return was

not optimal, resulting in her troubles "reading" herself and others. We want to help her be more effective in reading herself and others so that she can have meaningful relationships that, in turn, allow her to make sense of her experiences and gain trust in the value of relationships. The first step to reading others is to *slow down and reflect* on what we are observing or what might be happening. This is the mentalizing process and the process that the therapist wishes to instill or rekindle in the client. Figure 7.1 captures the elements of this process visually.

The first step to reading others is to slow down and reflect on what is happening.

To illustrate how we might stretch out a ping-pong (serve-and-return) between therapist and client, we imagine the first session after MJ has been given her formulation (see Box 7.1).

Box 7.1. Serve-and-Return with MJ

MJ: I'm still feeling pretty down.

THERAPIST: Can you tell me a bit more about that?

MJ: Nope *(she sighs)*: Just feeling very down.

THERAPIST: I can see that you are feeling down. You are hunched over and you are not making a whole lot of eye contact. Can you tell me what is going through your mind?

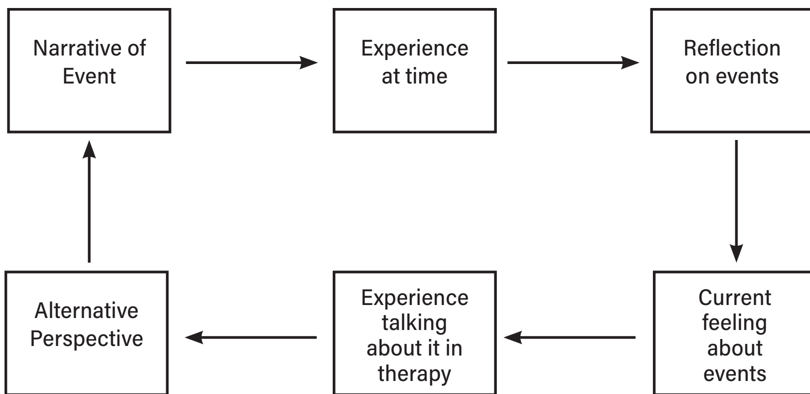


FIGURE 7.1. The mentalizing process to "stretch" out the serve-and-return that enhances reflective capacity.

MJ: Not much. Too much.

THERAPIST: At the same time not much, and also too much?

MJ: Yes.

THERAPIST: So what is that about?

MJ: I don't know. I don't want to think of anything because it gets too much.

THERAPIST: You are worried you will get overwhelmed?

MJ: Yes.

THERAPIST. Okay . . . I can see it is a lot for you. For me to try to see it from your point of view, can we imagine we are watching a movie of MJ's life? If we were, what would we see?

MJ: It would be a very sad movie.

THERAPIST: What would we see?

MJ: A girl who finally found someone she can love and then for it to be taken away.

THERAPIST: So walk me through it. I know that your boyfriend was arrested, but I don't have a clear picture in my mind . . . actually, can you tell me his name?

MJ: No, I don't want to share his name. There are still ongoing court proceedings and what happened to him . . . well . . . it's very serious, and I don't want anyone to know what he did. He did not do it, but they might think he did.

THERAPIST: Wow, okay. Hang on . . . I missed all of that when we spoke before. I want to make sure I get a clear picture. I'm trying to get a sense of what happened when he was arrested and how it affected you at the time.

MJ: I can't talk much about what actually happened because that might put him at risk. The case is ongoing.

THERAPIST: I think I am beginning to get the picture. What can you tell me? I'm trying to get a clear picture in my head of what happened.

MJ: Basically, he did something. I don't even know whether he really did it or not. I don't think so. It's a horrible thing. Then they arrested him and he has been in jail ever since.

THERAPIST: Can we rewind to the moment when he left. What was that like for you?

MJ: I fell apart. I could not eat. I could not work. I could only smoke. And Lexi.

THERAPIST: Lexi?

MJ: My dog.

THERAPIST: Can you tell me about Lexi?

MJ: She is the only thing keeping me alive right now.

THERAPIST: *(waits)*

MJ: *(. . . begins to cry.)*

THERAPIST: I am so sorry, MJ. Let's just hang tight for a moment . . . perhaps we can take a break from talking about this for a bit.

MJ: *(Cries softly.)* I'm sorry.

THERAPIST: I think I am beginning to understand. Can we talk a bit more how this is impacting you? Are you okay with doing that?

Following the process depicted in Figure 7.1, the therapist begins with the narrative of an event. Without getting too bogged down in the details of the event, the therapist is interested in the experience of the client at the time of the event, as well as the impact the event has in the here and the now. The focus remains on mental states associated with the event rather than the event itself. While the details of the event itself are important, there is a constant move toward understanding the internal states the client experiences in reaction to the event. Thus, once the mentalizing therapist has elicited the facts around an event, she then rewinds to establish the internal experience of that event. Ultimately, the therapist wants to understand what the impact of the event is on the client today—in the here and now. This is because in mentalizing work we want the client to understand that representations are formed about events, and that these representations are just that—replicas, albeit important replicas, of reality.

Crucial in this process is the fact that the therapist cannot do the work for the client. Indeed it is important that the therapist avoid mentalizing *for* the client. In our experience, this is something often misunderstood in mentalizing approaches to therapy. Nor does the Mentalizing Stance ever imply that the therapist knows what the client is feeling, or that the therapist tells the clients what they are feeling and why. Rather, the *therapist consistently invites the client to reflect*—to mentalize herself and others in her story. Put differently, the therapist is not mentalizing for (i.e., instead of) the client, but she is trying to mentalize the client from the position of a concerned outsider. This is not the same

Representations formed about events are just replicas of reality.

as mentalizing for the client. There are similarities with how, in childhood development, mentalizing is fostered through the experience of "being mentalized just well enough" by another (usually a parent). Mentalizing, remember, is not mind reading. It is the act of trying to estimate, imagine, work out, guess what states of mind might have occurred to make sense of a behavior. Thus, our efforts to mentalize our clients might have value in helping them experience their state of mind as "amenable to thinking about," or better still, creating some sense of feeling understood. Above all, the intention behind our mentalizing is that our efforts will invite or evoke from our client mentalizing efforts to improve upon our efforts, or at least to join with us in this act of benign puzzling out. Being somewhat or partially mentalized by another person stimulates our own mentalizing.

Here we arrive at the critical point: the most powerful way to invite, stimulate, or reawaken mentalizing in another mind (starting with the way the parent interacts with her infant) is to mentalize that mind. So, the therapist does not engage in mentalizing *for* (i.e., in lieu of) her clients, but instead tries to mentalize them from their own position or context.

MENTALIZING FROM A POSITION

Mentalizing is an act of imagination—we have learned this already. But we cannot (as therapists or as any human being, for that matter) mentalize from an imaginary space; we can only mentalize from a position, a grounded position from which we are in relation to the rest of the world and to other minds. To be operating from a Mentalizing Stance, the therapist must understand and be aware that she is holding a position. Of course, none of us could ever not hold a position in three-dimensional space, and what else is a "stance" but a kind of position? But the mentalizing therapist should consistently try to hold her position as much as possible in awareness, **holding the balance,** as it were, between mentalizing her own mind and her client's and sustaining awareness of their relational context.

The grounded nature of a therapist's position will inevitably involve being in relation to a range of "bearings" or "coordinates." We are less interested here in the coordinates relating to three-dimensional space and much more in those that relate to the *social*

construction of reality and our specific position within this, things such as:

- **Our personal values and intentions:** Are we really clear why we are here? Are we motivated to resist systematic discrimination and stigma, and to work in our client's best interests? Can we state these values and intentions with confidence to ourselves, to our supervisors, to our clients?
- **Our personal emotions and sense of understanding or not yet understanding a situation:** Are we able to sustain enough thought and feeling awareness to notice when we are tired, anxious (about our client, or other parts of our life), aroused by anger or fear, and when we feel unclear or confused as well as when we feel (perhaps unduly) certain? Can we own these feelings as our own?
- **Our identity, cultural assumptions, and beliefs:** Are we able to describe our sense of self and the various protected and other characteristics (race, gender, sexuality, age, class, etc.) that may contribute to our own perspectives and our own biases, and consider how these may impact upon our client?
- **Our social roles and responsibilities:** Are we alert to the nature of our role as therapist or practitioner, and in particular the dynamics of power that this might encompass for our clients, as well as our professional codes of practice and duties of care and of candor?
- **Our implied or explicit markers of power:** Many of the above features, particularly, perhaps, our role as a helping professional, may position us in a hierarchical way that is less visible to us than it is to those whose position renders them vulnerable to such power. Can we remain alert to this, and confident to explore what such things mean for our relationship with a client? How would we know if they were unhappy about something, or afraid to challenge us? How could we adapt our practice to facilitate better communication across such boundaries of power?

It is bearings such as these that define our position, that ground us, and that also separate or differentiate us from our client. That difference may allow us to use our own perspectives, thinking, and

imagination to her benefit. Conversely, if forgotten, ignored, or left completely unexamined (unmentalized), this difference may equally become the grounds for misunderstanding or even worse, harm.

MENTALIZING ACROSS BOUNDARIES OF POWER

The mentalizing therapies grew out of an increasing awareness of the potentially iatrogenic (harm caused by the clinician or the treatment) effects of therapy, and because of this, the need for active attempts to minimize such harms. Mentalizing can in many ways be understood as the science of misunderstandings, and our understanding of it is predicated on the fact that our "mind reading" is at best partial, often fleeting, and never infallible. Crucially, this goes for us therapists as well as for our clients.

In this it can be argued there is the opportunity for an important and overdue sea-change in the power dynamics of the therapeutic relationship. The mentalizing therapist brings her position (with all its inevitable possibilities for unconscious bias, discrimination, or even oppression), which includes considerable power—sometimes just in the mind of the client because the therapist is identified as having some expertise about the mind and human suffering, and sometimes in much more explicit ways relating to mental health and other legislation, professional obligations around information sharing in situations of risk and so forth. However, the mentalizing therapist's method of working is predicated on an understanding of this specific state of mind that they know to be universally fragile, and which they expect to fail in their own exercising of it. So the mentalizing therapist brings, alongside their mentalizing, an enthusiasm to notice and learn from its failings. This is a long way from the days of "the doctor knows best" or the elevated unchallengeable expert.

Mentalizing is at best partial, often fleeting, and never infallible.

Despite this, the mentalization-based therapies have to date included in their texts and trainings rather limited explicit emphasis on developing awareness of power relationships and of the possibilities for transcultural or other misunderstandings across significant differences, especially where power is at play, or where systematic

bias and discrimination are possible or even likely. In contrast, for systemic practitioners this thinking is a foundational aspect of the approach (and from them, in the opinion of these authors, the mentalizing therapies can and should learn much, and quickly).

It is curious that there has been relatively sparse attention to mentalizing across boundaries of power, culture, race, gender, faith, and other human differences in the MBT field, especially as it relates to the potential for mental health interventions to become unwitting collaborators with systemic discrimination or oppression. As mentioned, this may be a feature of the relative youth of MBT as an approach, but perhaps also because mentalizing approaches have often been seen as an augmentation of existing core therapeutic skills, often delivered via relatively short affordable trainings to already-trained clinicians in which it was simply assumed that such anti-discriminatory and reflective practice was already in place. It is all the more surprising that the content of trainings has somewhat neglected culture, power, and discrimination since there is a compelling evolutionary psychology argument that suggests mentalizing might have something helpful to offer in this territory.

The development of the prefrontal cortex and the capacity to mentalize has been argued to have evolved in response to the requirement for a transcultural communication aid. Our ancestors needed a way to minimize violence between early hominids. Their settlements would have been much more atomized, perhaps with dramatically different language forms and customs even from one village or settlement to the next. So meetings at borders would have constantly created opportunities for intercultural misunderstandings and the potential for lethal aggression. With the capacity to mentalize humans evolved the opportunity for a pause, perhaps staying the hand for just long enough to decipher that "this facial gesture, which looks so rude to me, doesn't seem to mean to them what I currently think it means."

MENTALIZING BEGETS MENTALIZING

So the therapist's Mentalizing Stance is directed at taking up and holding (in awareness) a position from which she tries to mentalize the client as accurately as possible, all the while knowing this

mentalizing will never be completely accurate. Is this ultimately a fool's errand, then, and rather dispiriting for the therapist who when she began training aspired to some kind of mastery? There are similarities with how, in childhood development, mentalizing is fostered through the experience of being mentalized *just well enough* by another (usually a parent). Studies by Ed Tronick and colleagues showed that mothers who had previously demonstrated their own secure (adult) attachments, who were observed interacting with their own infants, actually only offer perfectly attuned (as far as we can gauge) reciprocation in about 30% of microinteractions. That suggests that we (even mothers with their own infants) make minor mentalizing failures in 70% of our interactions. Even more telling, mothers who were found to be super attuned (scoring nearer to 50% accuracy or more) actually raised infants who turn out to be slightly *poorer* at mentalizing tasks in later life. This is a wonderful experimental instantiation of Donald Winicott's championing of the "good enough" mother, who is of course actually the best of all possible mothers. How so? Mentalizing, remember, is not mind reading; it is the effortful act of estimation, imagination, and working out (yes, guessing) what states of mind, in what contexts, might have occurred to make sense of a behavior. Thus our efforts to mentalize our clients, just like those mothers—*even if imperfect*—may still have value in helping them experience their state of mind as being at least "amenable to thinking about," or better still at times creating some sense of feeling understood. Here it is the therapeutic *intention* (remembering our values-based position described above) behind our mentalizing that particularly counts: our own benignly intended efforts to mentalize the other may in turn invite or evoke their own mentalizing efforts, perhaps by joining with us in this act of benign puzzling out, but better still (and here is the therapeutic value in benignly intended failures) to improve upon our efforts.

Consider when the therapist reads the client slightly wrongly. This might be similar for an infant, when perhaps her mother misinterprets her grimace as a smile, only seconds later to discover that the grimace actually marked how her baby was busy heaving and filling the diaper. Errors such as these (so long as there is enough evidence of benign intention and there has been some successful mentalizing earlier) may actually stimulate the other person's mentalizing: "You actually got a bit of that right! That's nice . . . but not X. How come

you missed that, I wonder? How was I coming across, to give you that wrong impression? What is a more accurate way of understanding and explaining X to you?"

So we have considered how mentalizing can only come from a position, and that it will always be occurring in a context that involves differences and boundaries of power, and that despite this only partially successful mentalizing can still be enough to stimulate mentalizing in the client. Let's move on to look at what a Mentalizing Stance looks like in practice. The following utterances are good examples of the Mentalizing Stance—see if you can guess why these are considered mentalizing statements:

- "This may sound stupid, but can I just check this?"
- "What I don't understand is . . . "
- "Do you mind if I look around? I think I may be on a wild goose chase, but do you mind if I . . . ?"
- "I can see how you get to that, but when I think about it, it occurs to me that she may have been preoccupied with something, rather than simply ignoring you."
- "I notice that your voice changes when you talk about that. Does that make sense to you?"
- "Is that the way you see it too?"
- "So your mom feels this, but I'm wondering if you recognize this as something that happens at home?"
- "So what happened?"
- "How did you feel when that happened?"
- "What did you make of it?"
- "How did you manage that?"
- "What impact did it have on you?"
- "I can see how you get to that . . . what effect did it have on you?"

Taken together, we can characterize the Mentalizing Stance as incorporating a set of interacting elements. We lay out these elements with descriptions below. Keep in mind that something as visceral and performative as a stance cannot be conveyed adequately by checklists alone. The use of video feedback and supervision in the security of relationships of epistemic trust is essential if we are to develop the feel for this. Even so, the elements we list below constitute the criteria

by which we would judge adherence to the Mentalizing Stance. For instance, to what extent does a therapist embody a not-knowing, inquisitive stance? To what extent does the therapist monitor her own mistakes? To what extent does she interrupt or terminate nonmentalizing during the session? Does she hold the balance between different mentalizing polarities, and does she effectively mentalize her self to inform her work with her client? Let's now review each of these elements of the Mentalizing Stance.

NOT-KNOWING

In mentalizing work, the therapist is *not* an expert or authority. The focus is on the subjective internal world of the client, and only the client can be the true expert. Instead of being an expert, the mentalizing therapist can make some aspects of her own mental process transparently available to the client in a marked way, highlighting where their perspectives differ from or overlap with those of the client, and raising interest and curiosity to explore the origins of such discrepancies and concordances between the two minds in the room. This does not need to feel like disempowerment for the therapist; instead, she does not need to feel under an obligation to pretend to understand the nonunderstandable, but simply to *mark* the instances when she does not follow. As such, there is clear differentiation between client and therapist and their multiple perspectives (e.g., "Hang on, you're going too fast and I cannot keep up . . . I was not sure how you got from saying you were left out to saying that you are not wanted. Can we go over that bit again so that I can catch up?").

Only the client can be the true expert on her internal world.

INQUISITIVE, OPEN-SOURCE THINKING

Instead of pretending to know or assuming or deciding what the client is thinking or feeling, or the reason behind actions or feelings, the mentalizing therapist sustains curiosity and inquiry about them. The therapist is tentative and respectful, thinking (mentalizing) out loud about possible hypotheses. The therapist explicitly communicates the

intention to understand and—from her position—must feel a genuine intention to understand. This point is absolutely critical: a common error is for a therapist to imitate a Mentalizing Stance simply by asking lots of questions but to be asking about things that (if she reconnects with and reflects on her own position) she is not actually curious about. She is just doing lots of "I wonder . . . I am curious . . . " language, as if that makes her a mentalizer. That would of course be a highly teleological solution to the anxious rumination that "I don't think I am doing enough mentalizing." The inquisitive stance is achieved when the therapist has the courage and confidence to identify and share her authentic position: what it is that she does not understand and is genuinely curious to have explained better?

The therapist also communicates uncertainty for other good reasons: to elicit reflection, to challenge areas of premature certainty, and to kick-start the process of elaborating implicit (unaware) aspects of interpersonal interaction. We see this in reflecting responses such as "Wow, this is quite complicated, isn't it? You are going to have to help me out here. I've no idea if I'm barking up the wrong tree . . . but I wonder whether he got so angry because he had a completely different expectation about the situation? What do you think?"

An analogy might be helpful here, albeit one that comes from a different world of work. In computer programming there are various models or approaches for how to develop new software. Conventionally, there was the expert/ownership model in which a programmer, or small team, created a piece of software privately and then sold versions of this to users—often with some degree of lock-in so that the core of their program was encrypted and updates could only be issued from their "high command," and often for a price. Open-source programming emerged as a radical alternative approach in the last century and has been responsible for the development of products as diverse as the Android mobile phone operating system and the Chrome browser. It also has some interesting parallels with the Mentalizing Stance. Open-source programmers have a motto, which is "Release Early, Release Often." Unlike the expert/owners described above, they will publish fragments of code or little tweaks and improvements that they have written via public sites even when their creations are still works in progress. Their rationale is that in this way they get their ideas tested in the real world, and even more important, they get real feedback on how they are doing and the

opportunity for collaboration with other minds that might enrich the program. "Status" for an open-source programmer often consists in how many different ways her original idea gets picked up and used by others, who then create "forks" in her original computer code, which are different adaptations and applications of that original code. This may sound a long way from mentalizing, but imagine we now substitute "idea" or "understanding" or "plan" for the word "code," and we are suddenly closer to what the therapist's broadcasting and sharing of her ideas in a mentalizing frame is all about. Before we become too self-congratulatory, let us remember that ideas about feedback loops and transparent communication are not new; the systemic therapists have been exploring and developing elegant ways to use just such radical transparency for many years, building on ideas from cybernetics and developing techniques such as the "reflecting team" to put them into use.

The inquisitive stance is often modelled in trainings by reference to the TV detective Columbo, played by Peter Falk (now sadly deceased). Columbo is always happy to parade what he doesn't yet understand, accompanied by head scratching and a certain clownishness as he thinks aloud, and in that sense he constantly *puts his mind on the table*. Of course, in the TV series Columbo is often actually using this as a trick to outwit the villains, and he usually knows a lot more than he lets on, so in that sense this is a terrible example. However, the idea of being confident enough to share one's position of not-knowing and curiosity is helpful. This effort toward transparency can be translated into another element of the Mentalizing Stance, namely the therapist's use of self.

THERAPIST'S USE OF SELF

A psychoanalytic practitioner will use her sensitivity to experiences of countertransference in order to explore, deepen, and enrich her understanding of the patient's inner world. This is crucially different from what the mentalizing therapist's "use of self" refers to. In respect of a Mentalizing Stance, the therapist's use of self is another way for her to express (with a degree of humility) and explain her understanding of her own limitations, especially in relation to the impact of affect—powerful emotions in the here and now. So in that sense it is a psychoeducational technique. In addition, it is a way to

help manage the affect in the session, by taking responsibility for asking to find ways to reduce the intensity in the moment, on the grounds that "my mind will likely work more effectively if we can soothe things and reduce the temperature a bit." As mentalizing therapists use the phrase, "use of self" is not a technique directed specifically at discovering new things about the client's mind.

In the example of MJ above, a client is talking about her sense of distress and her thoughts of self-injurious behavior. Alternatively, a client may become angry and yell at the therapist. In situations such as these a response that acknowledges the impact that this powerful immediate emotional context has on the *therapist's* mind can help to rekindle mentalizing—by focusing not on the fragility of the client's mind but on that of the therapist. Understanding this needs a certain amount of nuance: it is important to emphasize that this is not a "cry for help" by the therapist to the client, but a confident affirmation that this fragility exists in all our minds, is quite normal, and that understanding this enables us to take planned action in order to manage it.

For instance, the therapist might respond to MJ's statements about suicide thus: "What you are saying about feeling absolutely helpless and as though you 'might as well be dead' is something I need to take seriously. No way do I want to underreact to this, but also I don't want to overreact. I want to respond to your awful pain in the way that is most helpful. As we both know, when we are worried it is harder for us to get that 'making sense' part of our mind to work as accurately as it does when we're calm and safe. That is why I am suggesting that—right now—we might need to switch into a bit of action, rather than talk. I think we need to do just enough to help me (but I guess both of us) feel things are safe enough in a practical way to allow us to get back into that kind of thinking (mentalizing) that we've talked about. What do you think we need to do so that I can feel confident enough about your physical safety to really be able to concentrate properly to help you move forward in a helpful way? I have some ideas, but you might have some too?"

HOLDING THE BALANCE

Balance is a word often used in reference to mentalizing. We have described how we understand mentalizing as dimensional (self vs.

other; cognitive vs. affective; implicit vs. explicit; internal vs. external) so that ideally there is movement back and forth across these polarities balancing their expression in ways that attune the mentalizing to context. Additionally, in relation to the three modes of non-mentalizing (psychic equivalence, teleology, and pretend), we have described how these are certainly not mere pathologies but are better understood as prementalizing modes of thinking. They are developmental building blocks toward mature mentalizing, which is the contextually appropriate balancing of these more primitive styles of thinking (just enough psychic equivalence to connect with the affect and hold a position, just enough teleology to act agentively upon the world, and just enough pretend mode to come up with new ideas about it). When working perfectly, the balancing act—rather as a tightrope walker constantly moves her arms up and down—involves a constant dynamic shifting of position, in response to feedback from internal and external sources, rather than ever being a fixed position. A similar analogy for this is found in the egg-shaped toys from the 1970s called Weebles. These took the form of little plastic figures, weighted at their round bases, which, according to the advertising slogan, would "wobble, but they don't fall down." Mentalizing acts just as the weight does in the Weeble—to pull the figure back into balance when its encounters with life (a child's fingers, in the Weeble's case) have knocked it off.

Thus, a central feature of mentalizing therapies is that the therapist stimulates mentalizing by trying to notice when the client (or herself) has gotten stuck in one or the other mentalizing polarity. The following question needs to be regularly posed in the therapist's mind, or indeed out loud: "In order for us to be thinking and reflecting in the way that we are, what are we not doing that might be a helpful counterbalance?" An effective way to stretch out the ping-pong (or serve-and-return) in the Mentalizing Stance is to engage in various kinds of *contrary moves,* which are the "wobbles" that over time keep things in balance. We will return to contrary moves in more detail in Chapter 8, but for now, we provide some simple examples to illustrate how contrary moves can be employed to hold the balance in the Mentalizing Stance.

So if a therapist has mainly been energetically trying to mentalize her client, it may be helpful to pause and mentalize herself for a moment instead: "What is it like to be me, here, trying to make

sense of MJ's despair at being separated from her boyfriend? To be finding it so tempting to assume, 'Ah, she's just young, she doesn't understand'—and then to feel bad for thinking about her thinking in such patronizing ways? How could I share my wish *not* to assume such things, without MJ worrying that I make assumptions? Maybe just explain it as my dilemma, exactly like that?" Similarly, if MJ had mainly been talking about her *own* sense of deprivation on account of her boyfriend's imprisonment, then the therapist might simply introduce *another's* perspective by asking something like: "What does your mom think of all this?"

If the therapist and MJ have been trying to mentalize an event from the past (that might be rather a cognitive exercise), it may be helpful to swing back to mentalize the present (and the affective experience): "This may sound a little bit off track, MJ, but I wonder what is this like for you right now? To be sitting here remembering and thinking with me about that last time you saw your boyfriend before he was taken away to prison. Apart from wondering why a judge would want to do such work, and how unsympathetic the justice system can seem, I can't help finding myself wondering what it feels like for you right now, to be recalling that awful day again, right here now with me?"

A focus on making sense by reference to external behaviors ("I think my boyfriend must have loved me because he bought me presents, and he'd always tell me he loved me") may be rebalanced by adding some focus on imagined internal states. You might ask, "I wonder what it might have been like for your boyfriend, with all the worry of that court case hanging over him for those months you were together. Do you think it was hard for him to find ways to talk about that to you? "

Thus, when a client is dysregulated, the therapist will often first validate the affect and support her but will soon try to balance the affect by saying something like "This is very upsetting to talk about. I understand that. Let's take a moment to step back from this so that we can think again." Conversely, when a client is intellectualizing (overly cognitive mentalizing), the therapist may say something like "I'm surprised you weren't super angry—I think I would have been! I think I would have lost my temper." If the client is overly focused on the external features of situation or person, the therapist may invite the client to reflect on the internal features of what might be going on

("Yeah, I can see how seeing his fists ball was noticeable to you . . . but what made him ball up his fists like that?").

So holding the balance requires that the therapist try to maintain an awareness of where their exchange has been located in relation to the polarities of mentalizing, and what (by being at one or the other end of a polarity) they might have been missing out on as a result. This serves to help maintain the therapist's position as lively, flexible, and active—constantly inquiring to see whether looking "from the other end of the telescope" might reveal some new piece of information or understanding that could enrich their experience of each other and the work.

MONITORING AND MANAGING AROUSAL

Another balance that requires to be held involves the therapist sustaining conscious and constant efforts to monitor patients' (and her own) levels of arousal and attachment activation. As we know, research shows that increasing levels of arousal are associated with decreasing levels of mentalizing capacity. Thus, the therapist has to establish and maintain a level of attachment activation and arousal that is of sufficient intensity to evoke and sustain mentalizing (if there is no arousal at all, there is no impetus to engage in the brain work of mentalizing) but not so intense as to overwhelm it. To this end, MBT follows a stepwise hierarchy of interventions, which we will review in Chapter 8 (the affect pyramid) when we introduce specific mentalizing interventions.

PUNCTUATING OR TERMINATING THERAPIST NONMENTALIZING

If all therapies were lined up along an axis, from "therapist extremely passive" to "therapist extremely active," then mentalizing therapies would sit more toward the active end. First, the therapist is always interested in developing that serve-and-return quality in the client's interactions. Also, simply *observing* a patient who is actively replaying well-worn nonmentalizing modes of thinking in a session is not seen as helping to foster change. Obviously, there is a balance to be found, and there must be space for a client to bring her whole self

into the session and feel listened to. However, once it is clear that a client is rather fixed in psychic equivalence or pretend mode thinking, then the therapist will use a variety of techniques to try to (re) introduce mentalizing into the dialogue. Most of these techniques are quite simple ways to recontextualize a dialogue in real time, and in so doing to trigger mentalizing—either about the minds currently engaged in that dialogue, or about whom that dialogue circles. Simply and mindlessly unleashing any old technique is of course teleological (solving by doing). But insofar as a technique is contingent with the context and more or less explicable in the mind of the other, then—like the action of feeding when hungry—this isn't as paradoxical as it may seem. It is important to be clear that mentalizing is not disconnected from action. Some of the key techniques employed to achieve this interruption or punctuation of nonmentalizing in our clients are described in the next chapter. Here, however, we shift to nonmentalizing in ourselves as therapists, because as well as applying this gentle intolerance of nonmentalizing toward the *client,* the therapist must also—at least as attentively—apply it to her own self.

As a therapist (as a human being, indeed), falling into nonmentalizing states is easy to do, especially in the pressurized setting of the consulting room, and especially if you care about your patient's well-being. Note that this is not an instruction to care less. It is a reminder to be aware that in caring we open ourselves up to feelings, and that high levels of arousal are the enemy of good mentalizing; so we live and work in a paradox. The more we care as therapists, the more the key facility that we have to offer our client—our mentalizing—is challenged, as we vicariously experience something of our clients' suffering or consider the risks they face and find ourselves aroused in relation to our own position of responsibility. Yet it is this empathic capacity implicit in caring that also allows us to achieve some accuracy in our mirroring of our client's affect, through our choice of words, our facial expressions, our posture and tone of voice. More than this, we know that it is precisely this "goodness of fit" that is closely connected to the facilitation of epistemic trust in our clients.

Imagine a therapist who sat apparently completely unmoved in the face of trauma or fury recounted by a client, or issued merely a tight-lipped and monotone response—"I can see that you are upset"—without any expression to indicate the magnitude of the distress she beheld. This, we argue, risks re-creating almost perfectly Ed

Tronick's "still face" experiments conducted with mothers and their infants (you can search on YouTube for examples) that are so painful to watch. The child searches for some recognition of self in her mother and deploys increasingly desperate attempts to evoke this as she temporarily offers a completely still face. Of course, the *containing* nature of a mother's ordinary reaction to her infant's broadcasting of distress is not *just* in the accuracy of her mirroring (howling back at a howling baby does not help), but also in her *marking* of her responses—as her own efforts to represent (note that compound word, *re*-present) what she has understood so far (see Chapter 3 for elaboration). Driven by her natural implicit-automatic mentalizing (at least until she's conscious of worrying from her own position), she emphasizes reciprocity, making efforts to increase "serve-and-return" interactions. She seeks sufficient eye contact, modulates speech tones to indicate not only that she has grasped the intensity of the affect that is at play, but also that what words she offers back are (just) her internal monologue that she wants to share—to check whether she is understanding something recognizable (another helpful compound word: *re*-cognize) to her child.

It is worth contrasting the stance that classical psychoanalysts might hold. A classical analyst does make careful attempts (most dramatically in the use of the couch, thus rendering the therapist invisible) to *reduce* the feedback from and impact of their own physical presence in the form of facial expressions and so forth. Instead, of course, the psychoanalyst is attempting to provide containment through her interpretations. Most certainly, psychoanalysts care about their clients too, and we are not suggesting that this different approach to practice cannot be helpful. But we would suggest that mostly this is the case for clients with adequate ego strength, and perhaps too for those who have some explicit awareness of the rationale for their therapist to deploy a "blank screen" approach (which is anyway an oversimplified and outdated caricature of psychoanalytic technique.) Here, we are simply contrasting the Mentalizing Stance as one characterized by efforts toward radical transparency and immediate authenticity. This stance offers a "warts and all" approach to the mind of the therapist. It is marked by humility and an explicit wish not to privilege certainty that might be comforting to the therapist but risks harm, and it eschews potent markers of power difference ("You show me yours, but don't expect me to show you mine").

For a mentalizing therapist trying to work in this stance of radical authenticity, if we see feeling worried about our client as a sign of professional failure, then we just supplant the antimentalizing impacts of caring with the antimentalizing impacts of a system promoting "professional machismo" and held in place by shame ("If I am worried, then I must be a bad therapist"). Shame, of course, has the effect of minimizing help seeking (via supervision—not necessarily from the client) in favor of a mind retreating into hiding and, more dangerously, into isolation. If this work does not make us anxious at times we are almost certainly in the wrong job. However, we do need to notice what is happening (back to our discussion of the therapist's sense of their position) and to have structures around us (techniques, and above all supervisory connections) that predict and help us to manage such situations. What follow are a few pointers for some of the commonest ways that therapists tend to lose their own mentalizing. These things *will* happen, so what a Mentalizing Stance consists of is an expectation of such small failures, a vigilance toward noticing them sooner rather than later, and a preparedness to share with the client what happened in order to learn ("What was the anxiety or the communication tangle that led me, or us, into this? What new understanding of our interactions and each other's minds has untangling this misunderstanding offered us?") so that "next time I might misunderstand or miss you in a different way, but not like this again."

It is important to emphasize the potential value in a misunderstanding and its corresponding failure of mentalizing, but without wishing to invite therapists into deliberate recklessness or carelessness (because failures of mentalizing will happen, however attentive we are). It is often this point, when a therapist (prompted usually by some communication from the client) uncovers this misunderstanding and develops a new understanding right in front of her client, that marks the deepening of the client's own relationship of epistemic trust and her own facility for mentalizing, so that changes become more possible. Anthony Bateman has often spoken of what is the proper question for therapists to ask themselves on entering the consultation room. It is not "What difficulty or adaptive deficit in the patient's mind do I need to understand and help to change?" Rather, it is the other way around: "What misunderstanding in my own mind do I need to change, so that my patient can look at me and say, '*Now* you understand.' "

Therapist Pretend Mode

In this vein, the mentalizing therapist will avoid, recognize, or recover from therapist pretend mode. There are several ways in which a therapy session can spiral into client–therapist collusion, which is another way to describe the risk of pretend mode. The therapist should watch out for these. They include being clever; making long, complicated interventions or explanations; getting caught in exchanges that could be characterized as psychobabble; theory-based assumptions and certainty that lead to long digressions during a session that are driven from these ideas (of the therapist) rather than being rooted in reciprocal exchanges and what the client is bringing into the room. Other missteps include:

- Attributing the client's *specific* experience to a *general* pattern rather than exploring and coming to shared understandings about those specific details
- Long silences that may feel intense (and in that sense "important") but that cannot be explored or made sense of
- Noncontingencies (that may feel justified at the time as ways to "manage the affect by changing the subject" or, conversely, as ways to resist a patient's perceived "efforts to change the subject"), which constitute additional pretend mode missteps
- Making use of transference to explore unconscious repetitions of the past in ways that sidestep what is occurring in the present session

It is important to recognize that all these maneuvers might well make it feel in the moment as if therapy is taking place. But on reviewing the session, the therapist might come to see that authentic emotions, reciprocity, and reflection were being avoided (e.g., "Well it is clear that you feel really angry because this experience has called up something very old and primal in you; something that you have kept buried for a long time but that has been brought to the surface in a very profound way"). Many of us in the world of therapy are easily and understandably excited by the ideas and the intellectual challenge of the work we do, and this is fine, *except* when we catch ourselves with a cloud of words coming out of our mouths. When this happens, we have ceased to be in *relation* with our client but instead are in relation

with our ideas and the rich pleasure of spilling silken-tongued words to the delight and thunderous applause of a fantasy audience (did you see what we did just then?).

So, the therapist's response to a recognition that pretend mode has crept into her interactions will always involve taking responsibility for this, naming it, and trying to track back to the point in the preceding dialogue at which something emerged that called forth such defensive behaviors: "Do you know, I think I may have led us into a bit of a distraction these last few minutes. We've been talking rather cleverly, and some of what we've said may be quite important, but I am just remembering what started all this theory-talk: I think it was when you spoke about wanting to be dead. I think that rather worried me and I don't want to lose that in all my other words. Does that make sense to you? Did you feel that I really grasped what you were saying, back then? Can we just track back and see if I might have sort of skipped over something?"

Therapist Teleological Mode

Therapist teleological mode should similarly be recognized and recovered from. Perhaps the commonest example of therapists falling into teleological mode involves their mechanical use of mentalizing language without engaging authentic curiosity from their true position. This is different from the pretend mode use of language described above, in which there is a certain luxuriating in the language and ideas, even if they are disconnected from the here and now of the session. In a teleological mode, language becomes just *something to do*—levers to be pulled that offer a sense of agency without having to interrogate any intentionality beyond perhaps the half thought that "I don't want to feel powerless" (or rudderless or vulnerable). At the beginning of this chapter we discussed the importance of the therapist needing a sense of her own position in order to have any notion of her stance. It is easy to forget to mentalize the self, so that one loses sight of "what I don't yet understand" (and by default what I am therefore curious to understand better) in favor of the comfort of having things to *do* ("it will feel better when I have asked some therapy-like questions" or "let me give her a breathing exercise to calm her down"). In other words, it is easy to fall into asking a lot of appropriately curious

and tentative questions as if these alone constituted mentalizing ("I wonder if perhaps you could help me understand . . . " "I am curious to know how you made sense of . . . " "I may have this wrong, but I am wondering if . . . "). This is not a failure unique to mentalizing therapists. Systemic therapists can fall into the same pitfall, with an empty deployment of circular questions, cognitive-behavioral therapists with yet another co-constructed diagram to link specific affect states with cognitions and behaviors, analysts with seeming interpretations or impressively lengthy silences—all these are examples of deploying mere technique devoid of true therapeutic intent.

So, in working with their clients, therapists often feel an urgency to act. What are some other indicators of our being drawn into teleology? A therapist may feel compelled to schedule an additional session to keep a client safe; or to run over a session if a client comes in late; or to cancel another appointment to make the client feel understood when she is upset about availability. Giving in to such quick fixes is usually a teleological response to some anxiety of ours (for instance that the patient will definitely hurt herself and it will all be our fault, and we will certainly lose our job as a result, or that the patient will hate us and drop out of therapy). Notice, by the way, the psychic equivalence that often drives us into teleology. Teleological responses have the effect of maintaining an avoidance of using the mind instead of actions to solve problems. Thus, it is important that the therapist consistently tries to bring the client and the interaction back to the minds that are involved, rather than shortcutting into action. It is also important that she own up and address what can be learned when this wasn't possible. At the risk of repetition, mentalizing failures by every therapist are inevitable; it is failing to predict and respond to these with honesty and an effort to learn when they do happen that is the real failure.

There are two obvious exceptions to this preferring of mentalizing over action. As discussed earlier, sometimes teleology is entirely context relevant, and this is not a new discovery. First, if a client is indeed evaluated as being at risk of a suicide attempt, she should go to the ER or at least have a more formal risk assessment and be helped to formulate an appropriate risk plan. This is not the time to be engaging in explicit-controlled mentalizing. Second, mentalizing therapy does not oppose the use of skills such as those found in DBT interventions (e.g., "tipping," eating ice, or putting one's face in cold

water) or the use of worksheets such as are frequently found useful in CBT. However, in these circumstances the mentalizing therapist should use the opportunity to broadcast explicitly why a particular teleological action is being undertaken in the context of how it advances the workings of the mind. For example, a therapist may explain that she thinks it would be helpful to get a sense of a client's daily schedule because "at the moment, I'm not at all clear how it happens that you end up feeling unproductive—and I'm wondering, if we record it, would we be seeing something in that data that may help us understand whether you are actually unproductive or whether you view yourself as unproductive?" Again, the therapist—in suggesting a clear action with a measurable outcome—still puts her mind on the table. Therefore, skills (e.g., emotion regulation or thought records) may be developed as a function of mentalizing therapy, but if we are true to our Mentalizing Stance they develop from the inside out, not from the outside in; and they explicitly form part of the content of therapy, their intention and function being marked out in terms of mental states.

MONITORING AND CORRECTION OF OWN MISTAKES

In keeping with the idea of recognizing therapist nonmentalizing, humility is a hallmark feature of the mentalizing therapist. The therapist models honesty and courage via acknowledgment and correction of her own mistakes. Crucially, mistakes offer opportunities to revisit, to learn more about contexts, experiences, and feelings (e.g., "I'm so sorry, MJ, I think I messed up just now . . . did I misunderstand what you were saying?"). It is not uncommon that a shift toward a deepened and more authentic relationship takes place after a mistake on the part of the therapist has been transparently noted, shared, and corrected. The authenticity of this stance does not require that a therapist deliberately make mistakes, but that she have the courage to expect, look for, and own them when they occur, as they inevitably will. In so doing, the therapist is at least implicitly marking how she values the enrichment of her own mind through building a more accurate understanding, as well as her belief that the client's experience is generally improved when she experiences herself as better understood.

Remember again how the Mentalizing Stance offers a "fit" to the requirement for transcultural sensitivity, and perhaps especially to nondiscriminatory, inclusive, and antiracist interactions that should be central to any therapist's practice. As described earlier in this chapter, mentalizing can be seen as a kind of transcultural interpreting module in the brain, introducing the hesitancy and care that allow meetings at the parish boundaries between us to be negotiated successfully, primarily by introducing the notion that "my cultural assumptions and mannerisms—that may be only partially visible to me—may have unintended impacts upon you. I may mistake things through ignorance or insensitivity. So I need to go slowly and be sensitive to the need to stop, check, and reverse if necessary where you and I have lost sight of each other's shared intentions."

Humility is a hallmark of the mentalizing therapist.

The reader will notice that in this chapter we spend a lot of time discussing therapist failures in mentalizing and what to do about them, more than we do on client failures. This is no accident. The therapist's Mentalizing Stance is a way-of-being-with that models the use of error-prone minds rather than showcasing (or showing off) a mind that has escaped the gravitational pull of this reality. It may become apparent to the therapist that she may have made a mentalizing error when something unexpected occurs in her interactions with a client, or when she notices that her client appears upset in some way, or when she catches herself behaving in a way that she remembers is often a signal for her own mentalizing failures. Mentalizing errors may be mine alone, my client's alone, or (more commonly) we may have both arrived at states of inaccurate mentalizing almost simultaneously. To be misunderstood is both upsetting and—in short order—disruptive to our own capacity to mentalize. Even if a mentalizing error on the part of the client is glaringly obvious, it is helpful for the therapist to remember that she must take responsibility for creating the context in which her client's mentalizing at that moment in time was placed under so much pressure that it seems to have collapsed.

Responding to any suspicion that there has been a failure to mentalize is thus most often a case first of highlighting the context and checking for shared understandings: "Can I interrupt for a moment? We seem to have got a bit out of step, and I am feeling as though the 'temperature' has changed a bit here. I am wondering if [or suspecting

that] I've missed something that I shouldn't have missed. Does it feel like that to you too, or is this just my feeling?" Initially, the therapist is inviting some shared reflection in the here and now as to whether this is how her client is experiencing things too. Of course, such an invitation to reflect on the here and now interaction between us is a prompt for the client to take a different perspective on the dialogue that she had until that moment been engaged in, to frame-shift, as it were, and reflect on questions such as "Do I feel understood, or misunderstood here? If so, how did that happen and why?" In other words, it is an invitation (back) into a Mentalizing Stance.

The client may respond in any number of ways to such an interruption: perhaps with relief that something important has been named that can now be explored and fixed, or with frustration that "this is slowing things down, and if only this therapist could just keep up." Whatever the response, the therapist's openness to the possibility that the mentalizing error is her own is crucial, but so is modeling this possibility with confidence too. A therapist blushing and overcome with shame is of little use to her client, especially if what is communicated is some kind of requirement for the client to reassure the therapist.

If the beginning phase of therapy is set up with care, a therapist will have explained quite early on in the most general terms that, as things move forward, she will try to find opportunities to expand on how she works, so that there are no unhelpful surprises. She will explain that this is so that the client knows what to watch out for and how to get the best out of her therapist. If a bit of self-deprecating humor is appropriate, these explanations might be referred to as kinds of "health warnings about me" that a client might benefit from knowing in advance.

Let's imagine another example (see Box 7.2). It is the second session, and MJ has begun talking at some length about her relationship with her boyfriend, who is now in prison. There was initially a sense of urgency in what she said, especially in relation to her sense of loss, but increasingly her recollections of the few short months of her relationship took on a kind of dreamy quality that led the therapist herself into a dreamy state, listening to MJ's seemingly idealized account but simultaneously wondering what MJ's friends must have thought of him and imagining what this man would be doing in prison right now. After about a minute, the therapist catches herself engaging in

a rather teleological stream of nodding, issuing a series of automatic "aha"s and "mmmm"s, as if that might make up for the fact that she has lost hold of exactly what it is that MJ is trying to explain.

Box 7.2. Monitoring and Correcting Mistakes with MJ

THERAPIST: MJ, can I interrupt for a moment?

MJ: What? Isn't telling you this stuff what I'm meant to be doing?

THERAPIST: Well, yes, but this is more about me making sure that I am doing what I am meant to be doing! I realized just now that I wasn't really quite as sure as I want to be about what you want me to really focus in on, and that if I wasn't careful I could end up listening but not really hearing what I should be.

MJ: So you're not interested.

THERAPIST: No, far from it. Look, I want to show you how interested I am, and I want to use this opportunity for one of those "health warnings" about how I work. Do you remember the first time we met that I said I would try to explain as we go along how I will be trying to be more helpful, or avoid being unhelpful, in our work together?

MJ: Well, interrupting me pretty much tells me you weren't interested, and isn't very helpful.

THERAPIST: Yes, I can imagine that. To find I wasn't interested in your sense of feeling so completely alone so soon after finding someone who you felt really understood you—that would feel absolutely horrible. And if my interrupting you sends you that message (that I am not interested) that would be a big problem.

MJ: So why did you interrupt me, then?

THERAPIST: I like that you can wonder about other explanations for my interrupting you (and I am sorry to have interrupted). You'll find that I do tend to interrupt as we go—more than I suppose I might do if this was just an ordinary conversation. Sometimes I can imagine this might be annoying—perhaps it was a bit just now—but it's important for me to explain that I am never doing it in order to annoy or hurt anyone! I mostly interrupt if I realize that I'm not really understanding what is going on. So I promise I won't ever sit and nod *as if* I understand and hear what you are telling me—not for a moment longer than when I become aware that there's something I don't really understand. That's when I'll interrupt. That can be annoying because it slows things down, but . . . it can also be helpful, I think, because it slows things down that often go past at such a speed that neither

of us notice what has happened and that we've perhaps lost sight of each other. I don't know if that makes any sense to you?

MJ *(hesitating)*: I guess . . .

THERAPIST: It's a bit like cars driving round: it's easy to speed on roads we think we know well, but speeding is often where accidents happen! I suppose I have the advantage of knowing that I definitely don't know these roads of yours, so I have to go more slowly and get your help in identifying some of the blind turns or misleading road signs!

MJ: So what now—what didn't you understand? I thought I was being pretty clear.

THERAPIST: I realized I was listening to you tell me about a relationship that felt—feels, I should say—incredibly different from other relationships in your life, but I was struggling to get a picture in my mind of this person himself. What do you think I need to understand about this young man that would help you to feel I'm getting it properly, and why do you think I've maybe not gotten there yet?

MJ: Nobody else ever seems to like him like I do. You'll be the same. At least I guess that's how I feel—like I have to protect him from everyone. No one understands him.

THERAPIST: Do you think that feeling misunderstood was something that you both shared, then? That helped draw you together?

MJ: Yes, I guess, maybe.

MARKING AND REINFORCING CLIENT MENTALIZING

The last element of the Mentalizing Stance has already been referred to quite a lot and is in a sense the most bluntly behavioral of its elements: if you want to increase any behavior, and here we refer to the activity of mentalizing, then you must reward it. What this translates into is giving attention to marking and describing examples of mentalizing competence when they occur. In many ways this is the most important of the elements—it is certainly often the easiest to leave out.

Part of the Mentalizing Stance is not only to mark and punctuate the flow when there is a breakdown in mentalizing (see above, and in the following chapter), but to also mark it (highlight it) when mentalizing occurs. This again involves interrupting—with appropriate apologies—to describe what it is you think you just saw and explain

why that seems valuable to you. This requires the therapist actively to scan or search for examples (or episodes) of good mentalizing by her client and to enlarge upon them when they appear (e.g., "Goodness, can we just pause here for a moment? You saw things from your mom's perspective there for that moment—completely through her eyes! That was pretty impressive, because there was a lot going on for both of you back then. How do you think you managed to see it so clearly from her perspective? If your mom had been listening to you just then, what do you think she would have made of hearing you put things in that way?").

As described above, some mentalizing practitioners give more formal psychoeducation on "what is the activity of mentalizing?" in early sessions, even setting up classroom sessions with slides or a whiteboard. Others prefer to offer this teaching element from examples that arise in real time, directly from the client. The benefit of using real-time examples to illustrate mentalizing is that this implicitly emphasizes that what is being taught is a skill your client already has. In the therapy we just focus on it, mark it out more explicitly, note its ordinary fragility and its value, and thus justify taking steps to protect it at times when it is ordinarily vulnerable to being overwhelmed.

That is easy enough if a client conveniently engages in clear episodes of mentalizing, offering examples of mind-minded language that is contextually congruent, relationally enriching, flexible in its perspective-taking, and so forth. However, what if a patient is caught in distress and nonmentalizing modes of thinking for 45 of the 50 minutes of her session and only manages a few minutes—perhaps even only a few seconds—of something that seems closer to active mentalizing? Then it is even more essential that the therapist is alert and does not miss it. If the therapist didn't appear to notice this effort (and mentalizing is always mental effort), then it would communicate rather powerfully to the client that this effort at doing things differently was not valued. On the other hand, marking and positively appraising this is a powerful affirmation of what the therapy is directed at building up. ("You suddenly got quite thoughtful just then, it seemed to me. I wondered if you noticed the difference in the way you were thinking and talking just then—when I interrupted you!—compared to just before, when you were certainly showing me how infuriating you can find talking to your mom at times? It is very

hard to get into that careful 'perspective-taking' kind of thinking, especially when we feel really angry or hurt, like I think you've been explaining you often feel—but you seemed to manage it just then. I wonder what you make of that?")

CHAPTER SUMMARY

The Mentalizing Stance is what drives therapeutic change. First, we contextualized the Mentalizing Stance within our sociopolitical context. We then outlined various elements of the Mentalizing Stance that serve as criteria for whether a Mentalizing Stance is maintained. These include not-knowing; inquisitive, open-source thinking; therapist's use of self; holding the balance; monitoring and managing arousal; punctuating or terminating therapist nonmentalizing; therapist monitoring and correction of her own mistakes; and highlighting and reinforcing client mentalizing. The process of mentalizing requires the clinician to first gain basic facts about events to bring them into relation with the mental states associated with them at the time, but more importantly, the impact of the event and its representation in the here and now. With these basic components in place, we are now ready to dig a bit deeper into specific mentalizing interventions in Chapter 8.

CHAPTER 8

Mentalizing Interventions

In Chapter 6, you learned about the basic structure of MBT (Beginning, Middle, and End). In Chapter 7, we introduced, as part of the Mentalizing Stance, the mentalizing process (Figure 7.1), which describes the recursive elaboration of the impact events have on an individual's affect in the here and now. You were then introduced to the key elements of the Mentalizing Stance, that is, the general attitude with which you will be approaching your sessions with a client, or—in keeping with the idea of a "stance"—"way of holding oneself in relation with the other." The goal of Chapter 8 is to introduce you to a range of specific mentalizing interventions that can support the process and stance of mentalizing. As a reminder, mentalizing therapies are about both therapist and client learning to be flexible in their moment-to-moment interpretations of self and others. We want to help our clients free themselves from rigid and fixed views of reality, taking up instead the freedom to explore different alternatives in order to find a fit that offers richer, more fulfilling relationships with self and others. To this end, the primary goal is to help the client attend to her own mental process and focus on how she and others may be thinking and feeling at any given moment. This requires the therapist to do two things at once: first, to constantly explore the current state of mind of the client, and second to offer up her own best current understandings of the client's state of mind (putting your mind on the table). In this way, the client's understanding may be informed and enriched by having access to a reflection of his mind

in the mind of a trusted other. Throughout this process, the therapist keeps a close eye on the level of affective (emotional) arousal of the client in order to match mentalizing interventions to the client's arousal levels.

We therefore think of mentalizing interventions as being arranged across a spectrum, organized according to the likelihood of a match with the client's level of emotional arousal (how "hot" the emotion is.) In this ladder of possible interventions, the choice of which level of intervention to use (ranging from shallower, less intense implicit mentalizing via simple empathic validations, up to deeper and more intense explicit mentalizing of the therapeutic relationship with a focus on affect) rests on two contextual factors; first, it is inversely related to the emotional intensity present in the room at the time, and second, to the patient's capacity to manage or regulate herself in the context of that arousal. These relationships between context and interventions are illustrated in the *affect pyramid* (Figure 8.1), where you can observe that low-intensity interventions such as *empathic validation* are used when the patient is overwhelmed with emotion, while higher-intensity interventions such as *mentalizing the relationship* can be used when the patient is able to continue mentalizing while "holding" (managing) her emotional arousal.

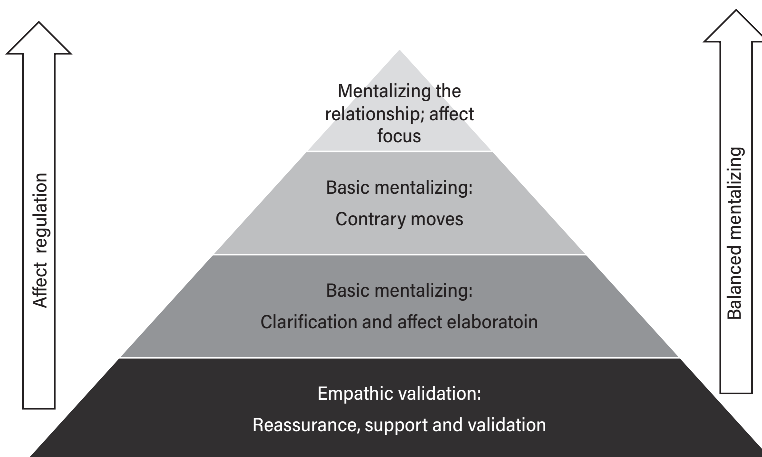


FIGURE 8.1. The affect pyramid depicting a spectrum of mentalizing intervention associated with the client's capacity to regulate affect and to mentalize.

We will now discuss each level of the spectrum of mentalizing interventions. Throughout the chapter we will use MJ (introduced to you in Chapters 6 and 7) as the case example.

LEVEL 1: EMPATHIC VALIDATION: REASSURANCE, SUPPORT, AND VALIDATION

In Figure 8.1, the black color at the bottom of the triangle indicates high levels of affective arousal, or conversely, low levels of the capacity to regulate affect. When a client is in a state of strong emotion, we use techniques of empathic validation (reassurance, support, and validation). We do this because we know from research that when a person is highly affectively aroused, balanced mentalizing shuts down. That is, while overwhelmed by emotion the client cannot think with you about what might be going on. Instead, it is often as though his thinking comes to constitute all that is going on (in other words, psychic equivalence). In all likelihood, therefore, your client will not be in a state to make much sense of you, and it might even be hard for you to follow what he says (he may not be articulating himself as clearly as he would in calmer circumstances, but neither is your own mentalizing likely to remain unaffected.) Your client is likely to be in any of the three nonmentalizing modes or engaged in hypermentalizing. Any attempt from the therapist to engage him in reflective mentalizing at this point in time will be ineffective, risking being perceived as completely missing the point, or worse, invalidating his experience. In that moment, our job as therapist is to get the patient to a place where he is calm enough to think with us again.

Thinking in terms of the mentalizing process (Figure 8.2), you will be using a lot of empathic validation in the highlighted portion of the mentalizing process, especially if the client is dysregulated. Empathic validation is used during other steps in the mentalizing process too, but it is critical to make use of it when clients are dysregulated in their efforts to convey what happened to them, and again when making sense of the current impact of the event on them. Here again, a client may become emotionally very aroused and you will have to ramp up empathic

When the client is in a state of strong emotion, use empathic validation.

validation to keep the temperature cool enough to stimulate reflective mentalizing. Let us briefly define what we mean by empathic validation.

Empathic validation is a somewhat parallel process to the "marked mirroring" that (see Chapter 3) a parent will offer back to an infant who is distressed. In that situation the parent returns to the infant a benign imitation of the state of mind (a cross or frightened expression, for instance) but simultaneously marks this mirroring with lots of ostensive cueing (eye contact, tone of voice, efforts at reciprocity). With this cueing the parent points out (as if offering subtitling, and the eye-catching equivalent of an ornate picture frame around his message) that "First, pay attention, this is important! Second, please get that it is not that *I* am angry/terrified/etc., but I am showing you what my best guess is about how *you* are perhaps feeling right now!" Insofar as the core emotional state the parent mirrors is reasonably accurate, the infant recognizes something of himself in the other, and insofar as the parent's marking is clear enough, the infant experiences this as signifying that he is not alone with this feeling, that it is at least understandable, and that it is a state of mind rather than a concrete (and perhaps eternal) reality.

Similar to this process in the parenting of infants and younger children, empathic validation in therapy requires some effort to convey (through facial expression, tone of voice, content of speech)

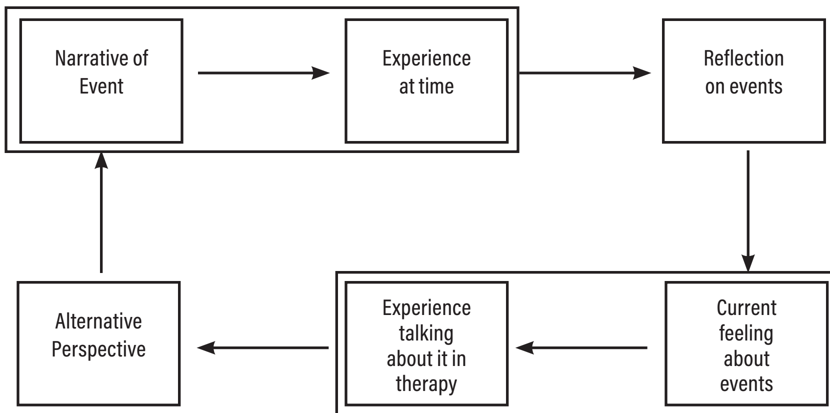


FIGURE 8.2. Aspects of the mentalizing process where empathic validation is likely to be used often by the therapist.

acceptance of the reality of the client's subjective experience. Empathic validation also marks for the client that he is not entirely alone in this predicament (it is at least understandable or imaginable to another person that they should feel this way) and that the therapist himself right now is not at the mercy of this same state of mind. Instead, the therapist shows that he can recognize it (name it, as it were) and in so doing offer at least the hope that it can be thought about, managed or contained. Table 8.1 defines what empathic validation is and what it is not.

There is a trick to empathic validation. Often, when a client is stuck at the affective pole of mentalizing, rebalancing is also necessary. Becoming increasingly sympathetic will potentially increase the

TABLE 8.1. Empathic Validation

What It Is	What It Is Not
• Recognizing the feeling in the client but not becoming overwhelmed by it • Being respectful of the client's narrative and expression • Offering an unknowing stance—you cannot fully know his position but can accept the force of the subjective experience • Demonstrating a desire to know and to understand coupled to sufficient urgency in one's reflecting back so as to mark one's recognition of how significant one understands the client's experience to be • Constantly checking back about your understanding—"*as I have understood it,* what you have been saying is . . . " • Spelling out the emotional impact of this narrative based on commonsense psychology and personal experience • Working for the client, but not acting for him—continuing to uphold the client's responsibility/agency	• Sympathy • Proscribed "mind-reading" statements such as: ▫ "What you really feel is" ▫ "I think what you are really telling me is" ▫ "It strikes me that what you are really saying is" ▫ "I think your expectations of this situation are distorted" ▫ "What you meant is" • Questioning the client's assertions

dysregulated affect either by positioning the therapist as a supporter in a cause, which may fire him up, or as someone who feels sorry for (or pities) him, which may deflate him. Instead, what is called for is an "understander." Consequently, the clinician offers empathic validation, recognizing the patient's experience as real, but rebalancing by directly addressing the challenge of being able to help right now, while the client is perhaps not in a state of mind that allows easily for the "making sense" function of mentalizing. We illustrate this delicate balancing act in Box 8.1.

Box 8.1. Rebalancing via Empathic Validation with MJ

MJ: Well, I can tell you that I've had enough of people. Fucking bitches.

THERAPIST: Oh-oh . . . What happened?!

MJ: You remember I told you about my friend Lisa and how she is such a good friend and how I can hit her up for anything and she will always be there for me. Except that one time with my boyfriend. Of course! Perhaps Connor is right. I never thought about this before. It actually all makes sense. Fucking bitch. That's the problem with trusting people. I can—

THERAPIST *(puts up her hand)*: MJ, hang on. I'm not following. And I want to understand. This clearly upset you a great deal. But it's going too fast and I'm struggling to keep up. Sorry, but this is one of those times I need to jump in and get you to drive slowly for me.

MJ: Okay, okay. I see, I see. Basically, Lisa fucking went and told Dylan that I slept with Connor. Can you fucking believe it? The man is in jail. He does not need to hear that!

THERAPIST: Oh, wow. So basically, you slept with Connor—he is Dylan's best friend, right?—and Lisa told Dylan about it? Am I getting it right?

MJ: Yes! Can you believe it?!

THERAPIST: Oh boy. Well I can see how the fact that Lisa told on you must feel like a big punch to your stomach. So can we just rewind a bit so that I can get a better understanding of how it was that you found out she told him?

There are a few things that we hope you notice in the excerpt in Box 8.1. First of all, the mentalizing therapist does not have to pretend to understand something that is not understandable. When a

client goes off on an illogical hard-to-follow tangent, you must interject as soon as you can (by which we mean to say as soon as you become aware of the fact that you are not following what is being said!).

In this regard, we often refer to the *mentalizing hand*. At its most basic or dramatic, you literally put up your hand to indicate "stop." In some MBT contexts (such as family therapy or group therapy), some clinicians even use a buzzer to bring a stop to any verbal outburst that does not make sense. The use of a video camera to record sessions offers another way to create a readily accessible mentalizing hand, too. A bit of preparation is required to set this up. It is important to explain to the client not only the purpose of recording sessions (to help the therapist think at a slower pace, with less emotional intensity) but also that it is unlikely that you will have time to watch the whole of every tape from start to finish. What you want is to be able to look at the important parts of the session. That is why you keep a large piece of colored card on the table. Explain to the patient, "We'll use this card, which either of us can pick up and wave at the camera if something happens that either doesn't make sense, or seems really important. This means I can skim through the video session on 'fast-forward' until I notice a hand waving the card, and then I can watch the preceding few minutes really carefully, in order to try to understand what is going on." With this shared understanding, when it is deployed in a session, the camera comes to represent a kind of third person or a mentalizing eye, and the minds of both therapist and client are invited out of the heat and immediacy of the interaction, and into imagining what the camera might have just seen. In other words, the mere act of waving the card can stimulate mentalizing in the room.

The key point here is that some form of punctuation is intended, to introduce a pause, and thereby facilitate better understanding for the therapist. Novice therapists often fear that it might be invalidating to interrupt the client or to slow him down when upset. Given the obvious (though often unexplored and sadly unacknowledged) power differences between therapist and client, there is also a risk that such therapist behavior could be read as asserting that difference in ways that could have a negative effect on the client's sense of self and agency. However, we have found the opposite: clients actually

report feeling heard when a therapist communicates that they don't understand and that they have a strong desire to understand better. Moreover, they can feel recognized as agentic selves worthy of respect when the unhelpful potential in power differences between them and their therapist is brought forth in transparent discussion: "This might seem like I am jumping in and interrupting you for the hell of it—like I'm just assuming I have the power and the right to do this—so first, I'm sorry for doing this, and second, I had better now explain why I am doing it."

Your primary goal in using the mentalizing hand is to enable you in your role and your position as therapist to better understand what is being expressed. Incidentally (and usefully), this punctuation often also has the effect of reducing the intensity of the affect in the room. It slows things down, reminds the client of the present moment in which another mind is diligently trying to make sense of his experience, and in that sense regrounds him—back here, in the consulting room, rather than there, wherever the client's mind had just taken him.

Clients feel heard when a therapist communicates that they don't understand but have a strong desire to understand better.

While this punctuating goes on, the therapist's empathizing and validating continue. By the therapist's interrupting in this transparent and marked way, the client's mind is invited into a "frame-shift" in which some consideration is invited about the mind of the therapist here and now, which is of course an invitation back into a state of mentalizing ("How and why has my therapist got confused here?" "How well have I been explaining this?" "Have I perhaps been abbreviating what I say because I am so upset?"). This process is of course made easier if in earlier sessions there have already been opportunities to talk about the nature of this work. The therapist may say, for example, "Interrupting in this way is one of our methods in this work; it is never an intention to shut down or invalidate your telling of your story, but instead it's a way of ensuring I can stay with you at such times by slowing us down. I don't ever want to be a 'nodding dog therapist' who pretends to be understanding when actually I am not."

Remember that the goal in empathic validation is not simply to

sympathize. Sympathy is feeling sorry for someone or placing oneself squarely on his side. Empathy is *feeling with* or *feeling alongside* someone, but as a separate mind. Nor is the goal of empathic validation to reflect or unearth underlying emotions (that would lead us into proscribed statements, such as "What you are really feeling is . . . "), but instead it is to find a way to resonate with the emotions so that the client feels better understood—so that he can feel more confident that the "flavor" or visceral experience of the reality that he has been expressing has been captured.

Proscribed statements (see Table 8.1) do not make the client feel as if the therapist is standing in his mental shoes but instead communicate to the client that the therapist has expert knowledge that the client himself does not have access to. This is a profoundly invalidating and potentially irritating or even unnerving experience, especially if the therapist's intuition (or knowledge) is actually incorrect. Nor does it foster agency, as it risks the possibility that henceforth the client may start looking to the therapist to constantly tell him what his true feelings are. Even worse, proscribed statements may lead to bickering with the therapist, arguing the niceties of different theoretical takes on what is going on, so that ultimately a pretend mode of communication fills the therapy. Finally, the goal at this level of intervention is not to question the client's assertions. Challenging an individual who is in psychic equivalence will at best strengthen any erroneous beliefs and interpretations and at worst alienate the client from the therapist. The motto for this level of intervention (empathic validation) might therefore be: "Listen in order to understand, not in order to respond."

Consider this example from the Bateman and Fonagy practical guide for BPD (2012, p. 246), illustrating how empathic validation combined with giving feelings of mentalizing competence can be instrumental in further increasing mentalizing capacity in a client:

CLIENT: My mother phoned me and asked me to come to help her pack before she went on vacation. I told her I wasn't going to do that. She said that I had always been a selfish girl given all that she did for me, which of course upset me and made me feel like a little girl.

CLINICIAN: Of course, given that you have worked so hard to have a different relationship with her [work done in therapy earlier] and

here she is treating you like you are a child, telling you what to do. Like your efforts have not yet had an effect [empathic statement indicating affect and the effect on her].

CLIENT: This time, though, I didn't put the phone down but told her that I couldn't help her pack because I had to go to work. She made me feel guilty about that, but I said that it was too late for me to ask for time off. In the end I was able to say that I would also miss her because of all she did for me.

CLINICIAN: It sounds like you really managed to explain something to her this time. How did that make you feel?

CLIENT: I felt so much better that I had not given in to her demands. I think that she just wanted to know that I still love her and that I would miss her when she was away. I sort of will.

LEVEL 2: BASIC MENTALIZING: CLARIFICATION AND AFFECT ELABORATION

Clarification

Once the temperature in the room has cooled down and you and the client can both think together again, you can move on to clarification and exploration. Typically, we think of clarification as obtaining a full picture of the details of the events (as depicted in the mentalizing process in Figure 8.3). It is only effective when the client is calm enough to help reconstruct what happened. It is important to understand that clarification is not simply repeating or reflecting back what the patient just said. That would be a form of low-level validation. Neither is it reflection upon the event; that is the metacognitive process of mentalizing, which comes later. Rather, clarification is simply asking the client for more information to help you more fully understand the facts. At this stage the discussion is focused on "what" more than "why," as it were. While clarification may be used at any of the steps in the mentalizing process, it will be most often used when a client is introducing an event that caused distress, as highlighted below. Again, it is vital that the therapist holds on to his own position of authentic curiosity about whatever it is that might require clarification. It is not helpful to ask clarification questions simply for the sake of it. The therapist must work to be as clear as

possible in his own mind about what elements of the story so far don't yet make sense. Who was present? Who believed what at the time? What was actually said or done "in plain sight," and—by default—what assumptions were required at that time to start the process of making sense?

In MJ's case, she came into session livid about the betrayal of her friend Lisa, who told MJ's boyfriend (Dylan) that MJ had cheated on him with his best friend, Connor. MJ was emotionally dysregulated when she first recounted the event, and the therapist had to slow her down to make sense of what happened. This process of slowing down, if repeated again and again, has the added bonus of beginning to model to the client how to slow herself down. The therapist's *mentalizing hand* ultimately becomes internalized, and the client, over time, learns to make use of it herself when the temperature heats up. Once the temperature begins to cool down in the room, the client is ready to be asked to clarify. The therapist establishes the important facts from the client's perspective. Once a clear picture of the facts has been obtained, and the client remains calm, the therapist will move on to **affect elaboration**. So let us pick up, in Box 8.2, where we left off with MJ.

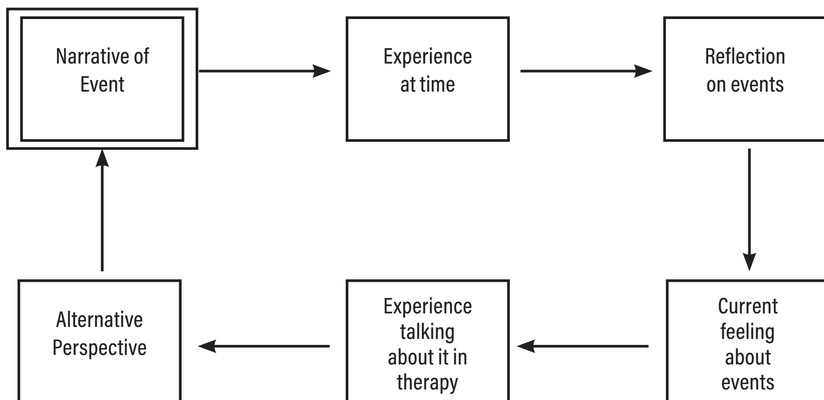


FIGURE 8.3. Aspects of the mentalizing process where clarification is likely to be used often by the therapist.

Box 8.2. Clarification

THERAPIST: Oh boy. Well, I can see how the fact that Lisa told on you must feel like a big punch to your stomach. So can we just rewind a bit so that I can get a better understanding of how it was that you found out?

MJ: Oh no. I can't even go there.

THERAPIST: Well, try to take me through what happened. The whole thing clearly has had a big impact on you, so I want to see if I can understand how you got here.

MJ: Well, I tried to call Dylan, and he would not take my call. It's all very difficult to get to talk to an inmate, you know. You have to call ahead to make an appointment to talk to him, and they just said he does not want to take an appointment to talk to me.

THERAPIST: That must have been super hurtful in itself. Did you know at the time why?

MJ: No, I did not. I was sort of just confused. So I called Lisa because I always hit her up whenever I need help, you know.

THERAPIST: So then what happened?

MJ: Well, the bitch told me, didn't she?

THERAPIST: Hang on, you're beginning to lose me again. Can we go back to where you are calling her? You are dialing her number and she answers and then what?

MJ: I tell her that Dylan does not want to see me, and I'm crying and then she says that she has something to tell me. I say what, and she says that she told him.

THERAPIST: When and how did she tell him?

MJ: I don't even know. I just freaked out and started yelling "fucking bitch," "what the fuck," and I threw the phone down.

THERAPIST: So at this point you still have very little information about how she told him and why . . . is that right?

Clarifying an event in this way is important because the client begins to see that in order to understand something, you have to have a detailed account of it. It is a common human reaction, especially for those burdened with the kinds of adapted responses that are described in BPD, to become overwhelmed with emotion quickly and

stop short of understanding a situation before jumping from (premature) certainty into action.

In the above example, MJ did just that. She did not stop, rewind, or reflect with her friend on the circumstances that led to the disclosure; instead, she switched into psychic equivalence and teleological mode to manage her intolerable feelings. By asking clarifying questions, the client, over time, will begin to internalize a clarifying stance and will become his own therapist in slowing down around an event to first get a clear picture of what happened before jumping over this process and straight into action. Through clarification, the client learns to slow down around the details of an event, so that an elaborated, detailed, and differentiated picture of the event can emerge. Another way of putting this is that, in times of crisis there is commonly a drive to simplify, so much so that it is easy to believe in those moments that the simplest explanation is almost by definition the truest. In fact, perhaps the opposite is true in many of the highest-impact human interactions or entanglements—that the truth, if it is to be found anywhere, is probably to be found only in the specifics and the complexities, things that require a certain amount of unravelling.

Affect Elaboration

Once the facts are known, the therapist begins to explore the affect associated with the event. While affect elaboration, like all mentalizing interventions, can occur at any of the steps in the mentalizing process, it is particularly important in gaining an understanding of the experience *at the time of the event,* as well as comparing and contrasting this with *the current feelings about the event,* as depicted in the Figure 8.4.

The critical point here is that the client learns (or is "re-minded") that events have an emotional impact on him, and that these inevitable impacts in turn influence the way our minds are able to make sense of things and each other in the minutes that follow such an impact. This process can be facilitated by normalizing the emotional impact of an event ("given your experience, it is not surprising that you feel X" or "I can imagine that if I was in that situation, and believed Y, I would feel very much the same"), and identifying, naming, and giving context to the emotion ("So I wonder, do you think

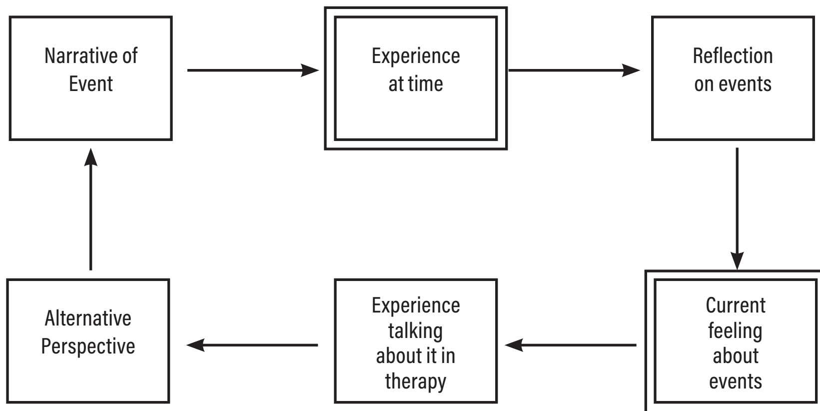


FIGURE 8.4. Aspects of the mentalizing process where affect elaboration is likely to be used often by the therapist.

it is anger that you feel [or felt]? Or something more like sadness?"). Trudie Rossouw (Sharp & Rossouw, 2019) often refers to the process of circling around an event and in so doing revealing successive layers of feelings, some of which may have been quite obvious at the time, but which—like the layers of an onion—have hidden others that are just as important, or perhaps even more important. In Box 8.3 we continue with MJ to show the therapist using affect elaboration.

Box 8.3. Affect Elaboration

THERAPIST: So at this point you still have very little information about how Lisa told him and why . . . is that right?

MJ: Well, it was clear to *me* what happened. She went and told on me. She probably did it on purpose! She went straight behind my back and threw away 15 years of friendship for what? For what? *(Tears well up in her eyes.)*

THERAPIST: So I'm trying to figure out if you are feeling angry or sad right now. You sound pretty pissed at her; but I also see tears, and I'm not sure if those are tears of anger or sadness.

MJ *(softly, sniffing)*: I don't know . . . I guess I just feel so betrayed.

THERAPIST: Well, it is natural when you trust your friend with a piece of sensitive information and she shares it with the person that would

be most affected by it, you would feel betrayed. What does that feel like . . . to be betrayed.

MJ: I really am pissed. I feel angry.

THERAPIST: I guess I would also feel a bit sad too?

MJ: I feel sad too. What a waste. But mostly anger. Like, yeah, I'm worth nothing.

In the excerpt in Box 8.3, notice how the therapist tries to elaborate the affect associated with the event—to build a richer picture of MJ's state of mind at that time. All of us, but perhaps especially individuals with the symptoms of BPD, find it hard to identify and differentiate the emotions unleashed at times of crisis. Positioned in a Mentalizing Stance of respectful and authentic curiosity, the therapist moves himself and the client toward uncovering shared understandings about the feelings associated with such an event, in addition to the current emotional impact of the event (as it feels talking and thinking about it now). Asking clarifying questions specifically targeting emotions is therefore another critical way of slowing down the serve-and-return with the client. Importantly, if this experience is repeated, the client learns that he can talk about emotions without becoming overwhelmed by them. Of course, bringing emotions into focus may mean that the client becomes emotionally dysregulated again. In moving nimbly back and forth between empathic validation, clarification, and elaboration, the therapist is demonstrating another aspect of holding the balance (described as a part of the Mentalizing Stance in the preceding chapter) and, in so doing, is showing the client that we can look at the contents of our own and others' minds without automatically becoming overwhelmed. We can put our minds on the table for discussion, reflection, and evaluation, and we will set aside time and effort to manage our emotions while doing that. We do this by keeping our *foot on the brake pedal* and moving forward only when the temperature allows for it.

Thinking back to the developmental model for personality pathology that we discussed earlier, we can see how therapy creates a kind of laboratory for enhancing through constant practice the fundamentals of interaction literacy. Remember that for whatever

Clarifying questions help slow down the serve-and-return with the client.

reason, this laboratory was not functioning optimally when your client was growing up, so that—we assume—she perhaps never, or only rarely, benefited from a serve and return that enabled her to learn to manage her emotions while talking about emotionally arousing topics. Therapy provides, ideally, the context to (re-)learn this, interaction by interaction.

LEVEL 3: BASIC MENTALIZING: CONTRARY MOVES

When the temperature has significantly cooled down and the therapist has some idea of the event and associated feelings, the session is ready to move into a reflective (meta-cognitive) mentalizing phase where the client's views can be challenged and alternative perspectives explored. Collectively, we refer to these mentalizing interventions under the umbrella term *contrary moves*. The therapist may often move seamlessly from clarification and affect elaboration into contrary moves and back again, being careful not to challenge when emotions are too hot. The main goal of contrary moves—just as with the earlier techniques—is to reinstate mentalizing.

As a reminder, when the balance in mentalizing is lost, an individual is left with what remains, which are the nonmentalizing modes of thinking (psychic equivalence, teleology, and pretend). When stuck in a nonmentalizing mode, we are likely also to find ourselves stuck at one of the extreme ends of a mentalizing dimension. There may be either hypermentalizing or undermentalizing.

The therapist's job is to move the client out of the nonmentalizing mode in order to stimulate reflective mentalizing that may generate alternative perspectives. While the therapist may make use of contrary moves during any step in the mentalizing process, it is most likely to happen during the steps of "reflecting on events" and "alternative perspectives" as depicted in Figure 8.5.

For each of the nonmentalizing modes, we use a slightly different approach to try getting mentalizing back on line. In Chapter 5 we presented a table of the therapist's experience typically associated with each nonmentalizing mode that may help signal that the client stopped mentalizing. Below, we now expand this table (Table 8.2), adding the contrary move the therapist may use to move a client out of his nonmentalizing mode. Note that we also add "what not to do"

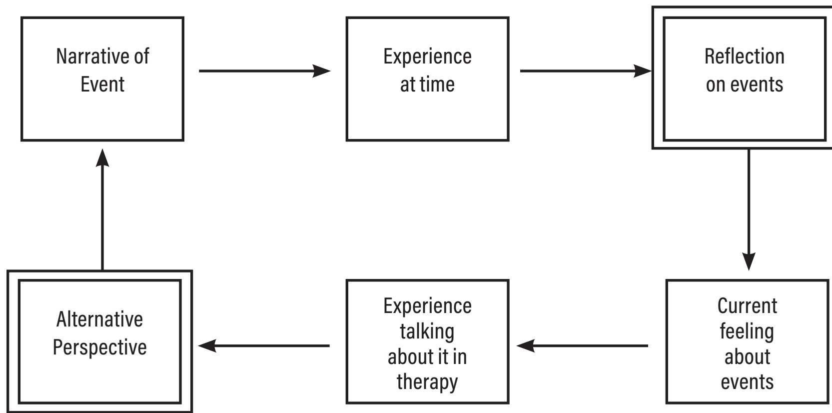


FIGURE 8.5. Aspects of the mentalizing process where contrary moves are likely to be used often by the therapist.

(that is, what actions to avoid because they might be iatrogenic, further exacerbating or strengthening the nonmentalizing mode).

To illustrate, we will return to the session with MJ. We left off where the therapist elaborated the emotions of anger and sadness associated with the betrayal by MJ's friend Lisa. MJ said, "I feel sad too. What a waste. But mostly anger. Like, yeah, I'm worth nothing." The therapist responded, "Worth nothing?"

Let's pause for a moment. What nonmentalizing mode may MJ be in right now? Previously she was expressing quite a bit of anger—to the extent that the therapist had a hard time following. The therapist had used the mentalizing hand, validated empathically, and requested clarification. When the facts of the situation were a bit clearer, the therapist then began to work with MJ to elaborate affect (anger and sadness), and MJ was able to differentiate the two emotions somewhat. While her emotion had dialed down somewhat through these interventions, she remains in psychic equivalence, where the actions of her friend Lisa have implications for what she believes about herself (that she is "worth nothing"). This fills her, on the one hand, with rage, but potentially also sadness and shame (although she does not express that these two emotions are relevant for her at the moment). She is not in teleological mode because she is not displaying an urge to act. She is not in pretend mode because we have a sense that her emotions are connecting to the event in an authentic way. Therefore,

TABLE 8.2. Contrary Moves to Move a Client Out of Nonmentalizing Mode

	Therapist's experience	Intervention (do)	Iatrogenic (do not)
Psychic equivalence "Because I think it, it is true"	• Puzzled. • Wish to refute. • Statement appears logical but obviously overgeneralized. • Not sure what to say, lost in argument. • Angry or fed up and hopeless.	• Empathic validation of subjective experience • Curious: "How did you reach that conclusion?" • Show marked puzzlement. • Link to new topic to trigger mentalizing, then return to topic of psychic equivalence.	• Argue with patient. • Focus excessively on content. • Pose cognitive challenges.
Pretend mode "Because I act like it, it is true"	• Boredom. • Detachment. • Comfortable: Patient agrees with your concepts and ideas or engages in intellectual debate. • Identification with therapist model, without questioning it. • Feels progress is being made in therapy.	• Probe extent. • Counterintuitive. • Challenge with humor or surprise. • Express own struggles to square the story with other contextually relevant facts (contradictory information, contrasting or unspoken emotions, the "elephant in the room") that challenge it, inviting the client's help in the task of integrating this.	• Nonrecognition. • Joining in with acceptance of the pretend as real. • Insight-oriented interpretations. • "Teaching"/skill acquisition. • Conflictual or triumphant use of statements that expose the client (insensitivity to the presumed anxiety that necessitated the pretend mode).
Teleological mode "Because I see it, it is true"	• Uncertainty and anxiety. • Wish to do something—medication review, letter, phone call, extend session.	• Empathic validation of need. • Decide to act in accordance with exploration of need. • Lay out the dilemma of doing.	• Excessive doing (exceptions in relation to immediate safety). • Proving you care by doing. • Skill acquisition.

we follow the advice in Table 8.2 for the nonmentalizing mode of psychic equivalence and make use of empathic validation, marked puzzlement, and switching to a related topic if needed. Let's see how that goes, continuing in Boxes 8.4a, b, and c.

Box 8.4a. Contrary Moves

MJ: I feel sad too. What a waste. But mostly anger. Like, yeah, I'm worth nothing.

THERAPIST: Worth nothing? . . . How do you get to that conclusion?

MJ: Well, if Lisa cared about me she would not hurt me this way.

THERAPIST: So the fact that she told Dylan means that she does not care about you? I can see that you could feel that way. I guess I'm still struggling to connect the dots though. Say we were watching this in a movie. There are two friends. They have been friends for 15 years. They have been through thick and thin . . . several boyfriends; one of them had an abortion; one of them had a parent commit suicide; they went to school together; they battled their addiction together. And then one day, the one friend betrays the other. How does that happen?

MJ: I guess we don't know . . . and we'll need to keep watching the movie to find out.

THERAPIST: I guess so.

(Silence)

MJ: So you think I need to find out more?

THERAPIST: I don't know. I just can't connect the dots, and it doesn't make sense to me. I guess it's *possible* that you are "worth nothing to her," and that alone explains her behavior. But I'm certainly wondering if there is more to it.

The intervention in Box 8.4a was quite effective. If we remind ourselves that psychic equivalence is about being certain, this intervention has moved MJ from a position of certainty to one in which she recognizes that she may be in need of more information before she draws conclusions. What matters here for our purpose is perhaps less *why* Lisa betrayed MJ, but more that MJ has begun building the courage to go back to Lisa to find out what happened; to get back into the serve-and-return with Lisa to negotiate a shared understanding

of their relationship. Put differently, MJ is developing the *literacy of interaction*.

Let's imagine a scenario, shown in Box 8.4b, in which the therapist makes a critical mistake in response to psychic equivalence, which spirals MJ into pretend mode. In that case the therapist will monitor her mistake (see Chapter 7) and will immediately try to recover mentalizing by making use of the interventions in Table 8.2 for responding to pretend mode. This will help us to remind ourselves that the measure of good mentalizing in a therapist is perhaps less about the number of mistakes he makes in a session, but more about the time it takes to notice these mistakes and to make efforts at repair. Mentalizing is the relational equivalent of the attentive and available roadside repair van, not the shiny sports car with a race-tuned engine.

Box 8.4b. Therapist Repairs a Rupture

MJ: I feel sad too. What a waste. But mostly anger. Like, yeah, I'm worth nothing.

THERAPIST: Worth nothing? . . . How do you get to that conclusion?

MJ: Well, if Lisa cared about me she would not hurt me this way.

THERAPIST: So why do you think she did it?

MJ: Well, I think Lisa has had her own problems. You know her dad committed suicide on her. It often happens when people have this darkness inside them that they somehow need to transfer that to others. I've seen this before. It is like there is something rotten inside that will need to come out even if hurts someone else. I had another friend who also had some serious stuff go on with her when she was little. What do you think brings that about—you know . . . why is it that this darkness is then carried around and pushed onto others?

THERAPIST: Well, those are big questions. I can tell you I don't have all the answers! But I think I got us a bit off track . . . I suppose I am less interested here in Lisa's life story and more interested in the connection between her betrayal and you concluding that you are worth nothing. Can we rewind to that point and look at that for a minute?

In Box 8.4b, when the therapist asked, "So why do you think she did it?" she asked MJ to do the impossible in that moment—that is, to engage in high-level mentalizing. Putting the scene into a movie is

a much more effective way of stimulating reflecting mentalizing. The direct question "So why do you think she did it?" requires too much information (conscious and unconscious) to be juggled all at once. The movie technique breaks that process down into smaller, more manageable chunks. So when MJ got asked this question she went into defensive pretend mode where she can "pretend" that she knows the answer while actually she engaged in psychobabble. The therapist, realizing her mistake, immediately put a stop to it. She owned up to her contribution in bringing a mentalizing breakdown and *put her mind on the table*. She expressed what she is really interested in so that they can get back to the point where MJ was actually beginning to mentalize. We can easily imagine a scenario in which the therapist might have engaged with the psychobabble, in which case, the pretend mode would have been maintained and the session wasted: "Well, those are big questions. There is certainly some research that shows that early traumatic experiences contribute to the formation of these defective schemas . . . " and so on. The lesson to be learned here is to steer clear of being clever. Pretend mode will often "pull for" cleverness in the clinician—a sort of mutual intellectualizing that should be avoided at all costs. It is important to distinguish between the unhelpfulness of such theorizing in this setting (instead of genuine serve-and-return interactions) and the truth or usefulness of such theories in themselves. $E = mc^2$ may be elegant and true, but it won't necessarily help you find the energy to leave the couch and go for a healthy run.

Let's now imagine a third outcome for the scenario (Box 8.4c), this time if the therapist makes a critical mistake in response to psychic equivalence, which spirals MJ into teleological mode. Similarly, the therapist will monitor her mistake (Chapter 7; Mentalizing Stance) and will immediately try to recover mentalizing by making use of the interventions in Table 8.2 for responding to the teleological mode.

Box 8.4c. Therapist Owns Up

MJ: I feel sad too. What a waste. But mostly anger. Like, yeah, I'm worth nothing.

THERAPIST: Worth nothing? How do you get to that conclusion?

MJ: Well, if Lisa cared about me she would not hurt me this way.

THERAPIST: But do you really think she does not care about you? You have been friends for 15 years.

MJ: I know she does not care about me. She would not have done it otherwise. I know what I need to do. I'm so pissed right now that I'm going to ruin her too. I have so much dirt on her—it's just not true. I can get her arrested if I want to. I'm going to call her parole officer right now and tell her what Lisa has been up to.

THERAPIST: Oh-oh! MJ—hang on! I think I messed up here. I think by challenging you in saying that Lisa *must* still care for you, I might have given you good reason to feel even more misunderstood and angry. I'm sorry. I've set things up for you to remember how pissed you feel again—to the point of you wanting to take action against Lisa. I understand that! I think if I felt this betrayed, then I would feel like perhaps wanting to get back at my friend too. But . . . can we just pause for a minute and go back to the point where you said you are worth nothing because she betrayed you?

MJ: Yeah, okay.

THERAPIST: I'm still trying to connect the dots. How do you get from her betrayal to your worth as a human being?

In this example the therapist responded to the psychic equivalence by challenging MJ, which perhaps felt invalidating—as if what was heard from the therapist was "Don't be so ridiculous, you have been friends for all these years." Hearing this response seems to have spiraled MJ further into doubling down on her sense of injustice by escalating into teleological mode. Like pretend mode, teleological mode is a defense, and like any defense, it stems from a powerful experience of something needing to be defended. Here, MJ is trying to avoid the intolerable feelings of rejection associated with her sense of betrayal by wanting to go over into action to neutralize these feelings. The therapist immediately owns up, makes use of empathic validation (and mentalizing the relationship—see later), and asks if they can start over in order to switch mentalizing back on. Throughout, it was MJ's arousal that signaled to the therapist whether they were still in a good place for reflective mentalizing or whether they needed to dial down the emotion through empathic validation. Note that in responding to the teleological mode, the therapist neither colluded with the action nor told her not to do it. She simply asked to return to the world of the mind instead of the world of action. Also

apparent in these examples should be the transparency and authenticity of the MBT therapist. Bateman and Fonagy often talk about "frank but fair" when trying to capture this aspect of the Mentalizing Stance. Marsha Linehan in DBT talks about "irreverence." Most clients, especially those with BPD, are quick to notice inauthenticity in a therapist and will vote with their feet.

LEVEL 4: MENTALIZING THE RELATIONSHIP AND AFFECT FOCUS

Like all therapeutic modalities that are psychodynamic, MBT is highly relational. Interpersonal avoidance is a strategy for many individuals with BPD symptoms to manage the pain of relationships. The clinical relationship itself is therefore an essential tool to facilitate change in individuals who are primarily mistrustful of relationships. When using the therapeutic relationship in mentalizing work, the intervention is called "mentalizing the relationship." The aim of mentalizing the relationship is to create an alternative perspective by focusing the client's attention on another mind—the mind of the clinician. Just as the client may be misattributing thoughts and feelings to others in his daily life, he may be misattributing thoughts and feelings to the clinician. Mentalizing the relationship is an intervention that spotlights these misinterpretations in a "fair but frank" way. This can be done effectively in the safety of the therapy room, but more important in relation to sustained change is whether it can later be practiced when the stakes are high in the outside world. Contrary to psychoanalytic approaches, the aim is not to give insight to the client as to why he is distorting his perception of the clinician's mind, but rather to engender curiosity as to why, given the ambiguity of interpersonal situations, he chooses to stick to a specific version of reality, and to develop confidence that such inquiry (as it is practiced in the therapy room) does not inevitably lead to conflict and pain. As with all mentalizing interventions, then, the goal is to stimulate mentalizing and give up the rigid psychic equivalent, teleological way of interpreting one's own and others' minds; it is an opening up to alternatives.

Six steps can be distinguished in the process of coming to mentalize the relationship, which are summarized in Table 8.3 at the end

of the discussion. Before we discuss the steps involved in mentalizing the relationship we want to communicate three important ideas. The first has been made in different ways in earlier sections of this book but bears repeating. In laying out six steps below, we do not want to suggest that these can and should be switched on and rolled through in smooth and exact sequence, as if therapy could be conducted like clockwork. Breaking down fluid, contextually rooted behavioral interactions into steps just helps us to clarify the sense of purposefulness in these maneuvers and to understand the way that a stance can work hand-in-hand with explicit intentions. For some, we can imagine that reading about multiple steps in a therapeutic maneuver could create a sense of anxiety and claustrophobia (how will I remember all these in the heat of the moment?), while for others this may help in creating clarity of purpose. Clinicians, through practice and the use of video and supervisory feedback, should be able (and feel permitted) to reauthor this particular type of interaction in their own authentic ways.

> *Mentalizing the relationship focuses the client's attention on another mind: the clinician's.*

The second point is that, as indicated in Figure 8.1, mentalizing the relationship only works when emotional arousal is low and when the client is capable of engaging in some reflective mentalizing. "Mentalizing the relationship" constitutes the tip of the affect pyramid. Given this, remember that you are likely to use it less than the other interventions. You will also be more likely to use it later in the overall treatment trajectory (although see the example in Box 8.5 of a session with MJ in which it was necessary to mentalize the relationship early on).

The third idea key to mentalizing the relationship is affect focus. Affect focus goes beyond affect clarification and elaboration. We chose to introduce it here rather than earlier because affect focus is so central to mentalizing the relationship. Often referred to as the elephant in the room, affect focus refers to bringing to light the shared affect or emotional atmosphere in the room. Pretend mode functioning is commonly activated

> *Mentalizing the relationship only works when emotional arousal is low.*

when the emotional atmosphere is not comfortable enough to acknowledge. Imagine, for instance, that in the middle of a session, a client suddenly becomes withdrawn and appears a bit disengaged. It is subtle, and so the therapist could easily ignore it. However, it is likely that the session will quickly digress into pretend mode. If, in contrast, the therapist can sensitively address the affect in the room, mentalizing will be enhanced and the relationship between therapist and client will be deepen in complexity and intimacy (e.g., "Hang on a minute. It feels as if something changed between us just now. Did I say something? Or miss something? Or am I just imagining things?" or "I may be wrong here, but I wonder if it is helpful to point out that to me it feels as though the temperature in the room here has changed a bit since I got us into talking about X . . . is that just me, or do you notice the same thing?"). Naming the elephant in the room is powerful because developmentally, this kind of sensitive response to the subjective mental state of the client may have been largely absent for a set of complex reasons throughout childhood. The therapist's taking time to try and define the feeling in the room with the client is therefore incredibly validating. It indicates that the unspoken can be spoken and that it is safe to share emotional aspects of the relationship. It is also safe to check out personal and subjective understanding in the context of the relationship. That both client and therapist perspectives are valid is an idea that is also central to the success of DBT with borderline clients. It provides the much-needed *in vivo* experience for clients to discover that one can hold two different perspectives while still remaining connected and cared for.

Affect focus often involves a comment on, or simple description of, the nonverbal cues of a client. Below, Bateman and Fonagy (2016) provide a nice example of affect focus when a client avoids talking about an anxiety-provoking topic.

THERAPIST: When we talk about this I think I notice that you start avoiding eye contact and keep looking away. Can you say why?

CLIENT: I don't know. My mind goes a bit blank.

THERAPIST: Can you describe it?

CLIENT: I feel anxious and I am nervous about talking about it.

THERAPIST: Perhaps that is something that we share—at the moment

> I am a bit anxious that if I keep asking about things it will make you more anxious and make you avoid things more. So perhaps both of us are uncertain whether to avoid or not.

This example clearly illustrates why affect focus is considered more than just affect clarification and elaboration. The therapist does indeed ask for affect to be clarified and elaborated, but it is elaborated *in the context of the relationship between client and therapist*. Note that at this point the attention is on affect related to what it feels like in the room right now (and not necessarily the affect associated with the event that may have started off the session). *Now* we are in the territory of mentalizing the relationship. If we break down further what occurred in the brief exchange above, we can see some of the steps that are summarized in Table 8.3.

Sometimes, the relationship has to be mentalized quite early on if it becomes apparent that there might be relationship factors that could pose barriers to treatment. Box 8.5 shows an excerpt from the second session with MJ.

Box 8.5. Affect Focus and Mentalizing the Relationship

MJ: I really don't think therapy is going to help.

THERAPIST: You feel uncertain about being here?

MJ: Well, it's mostly my mom who wants me to be here.

THERAPIST: Is that how you ended up here? Your mom sort of forced you?

MJ: Yes, she said if I don't come I can't stay in her house anymore. She does not like me smoking pot. So if I come I can keep smoking pot and staying in her house.

THERAPIST: That does make it difficult for you. You are in a sort of bind by the sound of it?

MJ: Yes.

THERAPIST: So how do we figure out whether there is something to be gained by being here?

MJ: I don't know.

THERAPIST: What is your worst fear in continuing on with therapy with me?

MJ: That I can't trust you.

TABLE 8.3. The Six Steps of Mentalizing the Relationship

Validate	• The process starts with validation because it is validation that will unlock the client's mentalizing capacity so that the relationship can be mentalized. • "Hang on—something just changed—you suddenly became quiet."
Explore the relationship	• The events in the session that generated the affect in the room are reviewed. • "What happened just now? Was it when my phone rang that things changed . . . or am I imagining this?"
Therapist owns his contribution	• The therapist actively tries to articulate how he may himself have contributed to the change in affect in the room. • "I think if I were with my doctor and his phone rang I would probably be annoyed too. I really should have remembered to turn the phone off. But I'm curious about what it was about my phone ringing that put you off so much?"
Collaborate to explore alternative perspectives	• The therapist and client work jointly in an exploratory process to evaluate alternative perspectives for the event that caused the change in affect. • "I can see how my phone ringing makes you feel that I don't have time for you. I'm wondering if there is not an alternative to that conclusion, though—that my phone ringing is just me having forgotten to turn it off before our session? Why does that not sound like a reasonable conclusion?"
Present alternative	• The therapist sensitively articulates the client's contribution to the change in affect. • "I think this is important, because it means that something like a phone ringing could trigger a feeling of rejection and misinterpretation in you; and if there is no chance to clarify it you may walk around with that dreadful feeling for a while."
Monitor and explore reaction	• The therapist ensures that the naming the elephant in the room did not hurt or dysregulate the client; go back to Step 1 if it did. • "Are you okay—it's pretty intense to put stuff on the table like this in broad daylight. How did it feel to talk about it so directly?"

THERAPIST: Do you know where that comes from—the fear that you can't trust me?

MJ: I trust no one.

THERAPIST: Okay—I understand. I'm basically a stranger with whom you now have to share really private things. I respect your perspective on this. What if you tell me every time I do or say something that makes you feel suspicious of my intentions? Then perhaps I can earn your trust that way?

In summary, then, the characteristics of mentalizing the relationship are summarized in Table 8.4.

CHAPTER SUMMARY

The goal of this chapter was to build on the knowledge gained in Chapter 6 (structure of therapy) and Chapter 7 (Mentalizing Stance) to introduce you to the affect pyramid, which depicts the spectrum of mentalizing interventions you will use, associated with your client's different levels of in-the-moment emotional arousal. You learned that there are four levels in the spectrum of interventions: empathic validation, clarification and affect elaboration, contrary moves, and

TABLE 8.4. Characteristics of Mentalizing the Relationship

- Talking about what is going on in the relationship between you and the client
- Remaining tentative
- Hypothesis testing
- Owning your perspective and ask for theirs
- Examples:
- "I can imagine how you end up feeling hurt by what is happening here." (Empathy)
- "And then—it seems to me—you are not sure if you want to be here (with me)."
- "You don't know how I will respond if I know that you want me to pay attention (understand, care) to you (what you are saying). Did I hear this right?"
- "No wonder you don't let yourself show me how your feelings get hurt (when you want me to notice, respond, care)."

mentalizing the relationship. We have provided you with an illustration of how these interventions might play out in a session with a client. You are now ready to begin mentalizing. In the final chapter, we will leave you with some closing thoughts on supervision, working in teams, and where and how to get additional mentalization-based training.

CHAPTER 9

Going Further with the Mentalizing Stance

Over the last three decades since Peter Fonagy first published his mentalization-based theory of BPD in 1996, MBT has seen significant growth in popularity. Across Europe and North America it has been adapted in a variety of mental health settings to include adult, adolescent, and child inpatient- and outpatient settings, community-based mental health services, step-down programs, and even school settings. Academic reports describing the effects of MBT have dramatically increased. The surge in popularity and interest in MBT led to a book on MBT (*Psychotherapy for Borderline Personality Disorder*) by Anthony Bateman and Peter Fonagy in 2004 that provided an overall account of the theory and practice of MBT with borderline patients. Soon after, several other volumes about classic MBT and adapted versions began to proliferate.

Our goal in this book has been to distill the basic elements of mentalizing interventions in the simplest terms possible. We aimed to answer some of the common questions we have heard trainees or mental health workers ask, such as "What does mentalizing mean exactly?" "As a mentalizing therapist, how do I know when I'm mentalizing? And how do I know when my patient is not mentalizing?" "I know I'm supposed to take a Mentalizing Stance, but how do I do that? What do I say?" "How can I teach my treatment team to mentalize when they have no psychodynamic training?" We have tried to answer these questions in the most basic terms possible. We have

aimed to distill the essential elements of mentalizing theory and practice to set the stage for more in-depth training to follow—information on which we will provide in this chapter. Before doing so, we want to discuss the important topics of supervision and working in teams. We also want to provide you with a self-assessment tool to test your knowledge about the Mentalizing Stance. You can also use this tool to assess your team or students as they begin to learn the Mentalizing Stance.

A NOTE ON SUPERVISION AND WORKING IN TEAMS

Working without supervision is unsafe. One of the features we have stressed repeatedly is the fragility of mentalizing, and the fact that this applies not only to the client but to the therapist as well. For us, this permission to be fallible in our work is a crucial and also a facilitating (even freeing) aspect of the mentalizing approach. We have briefly outlined how it can impact in positive ways upon the power dynamics that can easily and often complicate or disturb therapeutic work. We have also emphasized that it should be every therapist's duty to make explicit efforts to look for and to address or at least mitigate power differentials. Permission to be fallible is not an invitation into recklessness, though—it is a reminder of reality, and of our responsibility to remain connected to that reality.

Our theory makes it plain that mentalizing capacity both develops within the context of relationships and—when lost—can be recovered in the context of relationships. Hence, it is essential for you to have access to other minds that can mentalize you in the predicaments and dilemmas that will arise as you work therapeutically. The mentalization-based approach that emphasizes this more than others is AMBIT (Adaptive Mentalization Based Integrative Treatment; Bevington, Fuggle, Cracknell, & Fonagy, 2017), which applies mentalizing (in addition to client-facing work) to team-based practices between colleagues, to interprofessional practices across multiagency networks, and to the process of learning from our work. AMBIT stresses the paradox that this work makes us anxious, and that although this anxiety is actually a good thing (it means that

Give yourself permission to be fallible in your work.

we are rooted in the reality of what is at stake—a worker unmoved by the work is either burned out or sociopathic), it also threatens to undermine the very faculty that can best help our work, our mentalizing. Creating strong supervisory structures that predict our losses of mentalizing and do not evoke shame but instead promote effective help seeking between colleagues is critical to safe, sustainable, and effective practice. Teams can (and, we argue, should) create augmented support for their members' mentalizing in addition to the occasional intense support from formal mentalization-based supervision sessions. They can do this by attending to the creation of a help-seeking culture supported by social disciplines that structure effective help-seeking conversations on the fly.

The team practice known as "Thinking Together" is an example of this from AMBIT. As part of their team's efforts at constructing a shared culture and sense of there being a "we" engaged in this work rather than isolated minds, this practice involves workers collectively adopting an explicit structure for those particular work conversations that carry emotional weight. The structure of these "supervisory" conversations is as follows:

> *Teams can create augmented support for their members' mentalizing.*

1. Marking the task
2. Stating the case
3. Mentalizing the moment
4. Return to purpose

Rather than the help seeker just telling her story and assuming or hoping the helping colleague will automatically mentalize her need (and deliver accordingly), this purposefully "ritualized" form of helping conversation starts with an explicit definition of what the help seeker imagines a good ending to her invited dialogue might look like. This step is referred to as **marking the task:** it requires the help seeker first to kick-start her own mentalizing—to clarify and elaborate on the question of why she is approaching her colleague and thus to define and broadcast the kind of help she thinks she is looking for. This might be anything from "checking whether my risk plan seems to hold water" to "helping me make sense of why I feel so annoyed

with my client" or "thinking of some different way to start my next session to move things along." If the helping colleague realizes he is not clear about this task, he is empowered to pause his colleague for further clarification, so that, ideally, before the second step (stating the case—telling the story that has created context for the dilemma, whatever that is) he is able to listen with clear focus on what his colleague thinks will be helpful. Marking the task will also involve clarifying the time available for the conversation (these conversations can be conducted remotely by phone, on the fly beside a water cooler, or in more formal settings such as team clinical case discussions or a supervision).

During **stating the case,** the helping colleague is empowered to use a mentalizing technique that we have referred to, namely interrupting. Stating the case is deployed for the purpose of ensuring that the telling of the context doesn't slip into a kind of pretend-mode "storytelling" or teleological overinclusiveness. These two opening steps could, if overheard, seem quite blunt and "efficient." That's why this is a team practice: to ensure both parties have an understanding of the intentions behind this structure, and what to expect.

The third step is often accompanied by a conscious change of tone, even of posture, and this is **mentalizing the moment**. Here, there is a conscious effort to act more "as if" this is not a time-bounded conversation and to allow that imaginative, inquisitive element of the Mentalizing Stance airtime. Crucially, though, the helping colleague turns his mentalizing attention first to his colleague (who is present, unlike the client or other characters being discussed). What is vital is that the help seeker have an experience of being mentalized in her dilemma, not simply judged (psychic equivalence) or ordered (teleology). If there is some accurate mentalizing of her therapist's dilemma, it is highly likely that this will be validating and calming, and that not only will the help seeker's own mentalizing (which is assumed to have been challenged) rally, but also she is more likely to (re)establish epistemic trust with her helping colleague and thus be more open to take in perspectives that come from a position of less intense emotional arousal than her own. With colleagues who know each other well, this may take seconds, but what is critical is that there is some explicit effort toward a "meeting of minds" before together they mentalize around the other minds in the story who are not present.

Following this exchange it is the helping colleague's responsibility

to steer them back to the final step, **return to purpose.** This step is a reminder that this is a dialogue that both parties have consciously "contracted into" around clearly defined intentions (rather than a pretend mode exercise in intellectualizing or showing off). Often, the help seeker may at this stage have new thoughts of her own to answer her own task, and it is respectful for the helping colleague to enquire after these first, rather than force-feeding his own answers, though of course this might be where an important "view from the edge of the pond" can and should be introduced. More information and video examples of thinking together are available on the open-source AMBIT wiki manual (*https://manuals.annafreud.org/ambit*).

HOW TO GET ADDITIONAL TRAINING

An essential resource for additional training on mentalizing therapies can be obtained from the Anna Freud National Centre for Children and Families (AFC) website (*https://www.annafreud.org*). The information we provide here was largely taken from this website, as the AFC is considered the "mother ship" for mentalizing training.

The classic MBT training program involves four steps: (1) MBT basic course, (2) supervision, (3) MBT practitioner course, and (4) MBT supervisor supervision. Taking the basic course either at the AFC or one of the accredited international sites (see below) is required to progress on to other components of the MBT training program. Following attendance at the 3-day basic course, clinicians can participate in supervision to embed their newly acquired mentalizing skills while using them in everyday work. Participants should receive supervision from a senior clinician who has completed the MBT Certificate Course—Practitioner Level training. A list of accredited MBT practitioners can usually be found on the AFC training website. Once mentalizing skills are embedded in daily practice and clinicians have received ongoing supervision, they can attend the course for practitioner-level training. This program focuses on MBT for BPD, but training programs are now available for MBT for antisocial personality disorder, MBT for families, and MBT for adolescents. Following clinical supervision, MBT practitioners are able to train as supervisors in MBT. The amount of supervision required to become a supervisor is assessed on an individual basis. More

information on the requirements and pathway to become an MBT supervisor are outlined on the AFC training website. MBT supervisors are recognized by the AFC as having specific competence to act as a supervisor in their chosen model. A list of supervisors can be found on the AFC training website.

While the majority of the mentalizing training takes place in London by the AFC, the McLean Hospital, which is affiliated with Harvard Medical School, offers AFC-accredited trainings in Boston under the leadership of Dr. Lois Choi-Kain. In addition, the nonprofit Mentalizing Initiative under the direction of Dr. Robin Kissell offers MBT workshops in Los Angeles. "Pop-up" training courses are offered all over the globe by many of the AFC tutors, but these are primers for the actual accredited training offered by the AFC.

SELF-ASSESSMENT

Our last task is to offer you a self-assessment tool by which you can test your own (or trainees') knowledge of mentalizing therapies. Do consult the section at the end of this book ("Key Terms and Concepts") as you work through the questions. We purposefully do not provide the "correct" answer to the questions below, but in the spirit of mentalizing, we aim to get you thinking and reflecting on what you have learned in this book.

1. Are mentalizing therapies best viewed as a separate brand of therapy or a type of therapy that can be incorporated into any kind of therapeutic modality?
2. The definition of mentalizing states that mentalizing is an imaginative activity that has something to do with intentionality. What does that mean? Specifically, why is it important that the words *imaginative*, *activity*, and *intentionality* be included in the definition of mentalizing?
3. The most recent extension of mentalizing theory places emphasis on learning from the social environment, which includes the therapist. Which concept was identified to capture this process?
4. Why are mentalizing therapies considered in essence developmental?

5. What are the three prementalizing modes? Are they considered nonmentalizing in a 6-year-old? What about a 40-year-old?
6. Once mature mentalizing has been achieved, can a person still fall back into a prementalizing mode of thinking? If so, when is that most likely to happen?
7. A key feature of mentalizing therapies is that the therapist signals that her mind is separate from the client's. How does she achieve that?
8. Why is it important that nonmentalizing be immediately interrupted in the therapy process?
9. What are the mentalizing polarities and why are they important?
10. Name as many of the features of the Mentalizing Stance that you can think of, and try to define them.
11. What does an optimal mentalizer look like?
12. What is the purpose of the mentalizing formulation and how is it different from formulations derived in other therapeutic modalities?
13. Why are mentalizing therapies especially suited for working with personality challenges?
14. What is the mentalizing pyramid? Why is it important?
15. Name as many mentalizing interventions as you can think of. Try to come up with a clinical example that illustrates each.

CONCLUSION

In reviewing and reflecting upon these questions, we hope you discover you have learned something about mentalizing. We hope we have instilled in you a therapist orientation of openness and curiosity so that you can instill that in your clients. And we hope this book has paved the way for you to further explore mentalizing and its therapies. It was a pleasure to guide you through this introduction to a therapy modality that we love and treasure. We hope you will come to love and treasure it too.

Key Terms and Concepts

Below you will find key ideas and concepts associated with mentalization-based theory and practice. Throughout the book we have bolded these ideas and concepts; we define them in more detail below. Familiarity with these ideas and concepts will facilitate a deeper understanding of mentalization-based theory and practice and will help you apply a mentalization-based approach to your clients.

affect elaboration: a mentalizing intervention by which the emotional impact of an event is elaborated with a client by identifying, naming, and giving context to the emotion.

affect focus: often referred to as "the elephant in the room," affect focus refers to bringing to light the shared affect or emotional atmosphere in the room.

affect mirroring: the attachment figure's ability to respond with contingent, marked, and ostensive affective displays of her own experience in response to her infant's subjective experience, which in turn makes possible the child's development of coherent second-order representations of this subjective experience.

agency: defined as the capacity of individuals to act independently and to make their own free choices; also referred to as self-directedness or autonomy. Mentalizing fosters a sense of agency because it fosters self-understanding and associated ownership of motivations, values, thoughts, and feelings.

attachment disruption: when the attachment relationship between a caregiver and child is interrupted or disrupted though physical or emotional means.

attitude of openness and curiosity: the Mentalizing Stance requires an attitude of openness and curiosity where no assumptions are made about what a client may be thinking or feeling.

causal coherence: the ability to develop narratives that explain how chronological events in one's life are linked; it is a capacity that first develops in adolescence as it requires meta-cognitive and abstract thinking; it is conditional to the development of a coherent sense of self.

certainty: a firm conviction that something is the case; the quality of being reliably true or definitely true; certainty is a property of the psychic equivalent mode of thinking—the belief that because I think it, it must be true; certainty closes the door to learning.

collaborative learning opportunity: by signaling to the client there is a gap between his understanding and that of the client, the therapist creates a collaborative learning opportunity where shared meaning can be intentionally negotiated.

context-appropriate: optimal mentalizing is when mentalizing matches the context.

decouple mental representation from reality: the idea that humans have an awareness that what is in their minds is separate from reality.

developmental: mentalization-based theory emphasizes that mentalizing capacity develops within the context of the early caregiving environment, which offers a laboratory for children to practice the serve-and-return.

empathizing system: a term created by Simon Baron-Cohen to refer to more affectively-based mentalizing.

empathic validation: a mentalizing intervention by which the therapist conveys acceptance of the reality of the client's subjective experience, through facial expression, tone of voice, content of speech, with the goal helping the client feel understood.

epistemic hypervigilance: the opposite of epistemic trust; a mode of mistrust obstructing learning from occurring.

epistemic trust: an individual's willingness to consider communication conveying knowledge from someone as trustworthy, generalizable, and relevant to the self; or the ability to appraise incoming information from the social world as accurate, reliable, and personally relevant.

felt sense of knowing: when a client is able to mentalize herself.

flexibility of thought: refers to the ability to create and use new mental categories and concepts to reorganize our experiences; mentalization-based therapy stimulates flexibility of thought because it engages the imagination to consider alternative viewpoints, perspectives, and representations of reality.

flexing one's mentalizing muscles: mentalizing is something that we *do*; it is like exercise—the more you do it, the better you get at it.

generic therapeutic stance: mentalization-based interventions, by design, abandon specific techniques in favor of a generic therapeutic stance that cuts across therapeutic modalities

heuristics: mental shortcuts that our brains use so we can be effective thinkers; in mentalizing theory they denote errors or assumptions in thinking that need to be evaluated before motivating action.

holding the balance: the Mentalizing Stance requires the therapist to balance mentalizing polarities (self vs. other; implicit vs. explicit; internal vs. external; cognition vs. emotion) as well as level of therapist mentalizing capacity via-à-vis client mentalizing capacity while taking into account therapist and client level of arousal; mentalization-based therapies are a true balancing act.

hypermentalizing: excessive theory of mind: the overuse of mental state language to explain and predict behavior; social-cognitive processing that involves making assumptions about other people's mental states that go so far beyond observable data that the average observer will struggle to see how they are justified; overattribution of mental states to others and their likely misinterpretation; often associated with personality pathology.

hypomentalizing: less theory of mind: the use of thin, poorly articulated, simplistic, or ill-fitting assumptions about intentional states to explain and predict behavior, often inaccurately.

intentionality: central to mentalizing theory is the idea that thoughts and feelings are not random but that they are directed toward some object or state of affairs; the mentalizing therapist is curious about the connections between thoughts, feelings, and behavior to highlight real or perceived intentionality associated with them.

interaction literacy: becoming schooled in a productive, rewarding "serve-and-return" through optimal mentalizing.

learn from others: a critical recent extension of mentalization-based theory and practice is an emphasis on instilling in others the capacity to learn from the social environment through fostering the belief that knowledge gained from others is worthwhile—also referred to as epistemic trust.

marking: when an interaction partner demonstrates that she understands another's internal state while concurrently signaling that his expression concerns the other, not himself; marking is achieved by modifying (e.g., exaggerating, slowing down) one's own display of the other's affect, rendering it perceptually distinguishable from his expression of his own affect, or by simply highlighting what one observes.

marking the task: a concept that developed in the context of mentalization-based work in teams (e.g., AMBIT); refers to the action by which a mental health worker asks a colleague to clarify and elaborate on the question of

why she needs help, and thus to define and broadcast the kind of help she thinks she is looking for.

meaning-making: the process by which human beings actively construct meaning from their subjective experiences.

mental representation: the idea that what is in the mind does not reflect reality as it is, but a subjective, constructed replica of it.

mentalizing comeback: it is a fact that mentalizing will break down in interactions; therefore, the optimal mentalizer is someone who can coax the interaction partner back into the serve-and-return by making a mentalizing comeback—getting mentalizing back online so that an authentic connection with the other can be established.

mentalizing formulation: the mentalizing formulation makes use of all the information gathered on the client's history, mental state exam, and mentalizing profile and integrates it into a mentalization-based formulation. Because it is mentalization based, the formulation is necessarily also attachment based or relational, The mentalizing formulation may be communicated verbally or in writing to the client during the beginning phases of therapy.

mentalizing interventions: a range of actions or attitudes taken by the therapist to effect change in the client, keeping in mind the client's level of emotional arousal; interventions include empathic validation (Level 1), clarification and affect elaboration (Level 2), contrary moves (Level 3), and mentalizing the relationship and affect focus (Level 4).

mentalizing polarities: because mentalizing is a multicomponent construct, it is best understood as representing four polarities: mentalizing self versus others; cognitive versus affective mentalizing; implicit-automatic versus explicit-controlled mentalizing; and mentalizing utilizing interior versus exterior features; the therapist remains cognizant of where a client lies on these polarities, seeking balance among them.

mentalizing profile: in the beginning phases of therapy, the therapist assesses overall mentalizing, mentalizing style, mentalizing mode, and mentalizing polarities to build a profile of the predominant mentalizing tendencies of a client; the mentalizing profile may be communicated to the client as part of the mentalizing formulation.

Mentalizing Stance: a social learning paradigm of the psychotherapy process which implies that all evidence-based therapies must meet the client with acknowledgment and curiosity about his experiences and perspectives; an attitude or position the therapist takes that provides the context for epistemic trust and learning to occur. This attitude include not-knowing; inquisitive, open-source thinking; the therapist's use of self; holding the balance; monitoring and managing arousal; punctuating or terminating therapist nonmentalizing; monitoring and correction of one's own mistakes; marking and reinforcing client mentalizing.

mentalizing style: four types of style in an individual's thinking are assessed by the therapist: hypermentalizing, hypomentalizing, no mentalizing, and accurate mentalizing.

mentalizing the moment: a concept that developed in the context of mentalization-based work in teams (e.g., AMBIT); validating the experience of a colleague who is seeking help with a client dilemma to help stimulate mentalizing in the colleague.

metarepresentations (M-representations): a concept developed by Alan Leslie to explain how mental representations are represented in the language we use; M-representations consist of four parts (1) an agent, (2) an informational relation that specifies the agent's attitude (pretending, believing, desiring, and so forth), (3) an aspect of reality that grounds the agent's attitude, and (4) the content of the agent's attitude; we refer to it in this book as "thinking language," and it is an example of explicit mentalizing.

needs system: Pnina Klein contended that through parental reflective function (or by creating mediated learning experiences) the child develops a need to (1) seek clarity of perception, (2) search for meaning and excitement, (3) have successful experiences and complete tasks, (4) seek information beyond sensory experiences, explore, and ask adults for help, and (5) to think before doing. In sum, the child becomes an agentic learner who can make use of the environment outside the home (school, peers, extracurricular activities, and so on) to further learn how to live effectively and happily.

not-knowing stance: a hallmark feature of the Mentalizing Stance characterized by uncertainty, curiosity, and humility; being authentically unassuming about the content and intentions of another's mind.

optimal mentalizing: when a balance between mentalizing polarities is achieved and mentalizing is context appropriate.

ostensive cues: refers to the fact that communication not only transfers information but also signals that it is intentionally communicated to the recipient; ostensive cues are signals sent to the receiver that the information that is going to be shared is important.

overall mentalizing capacity: one of the aspects evaluated by the therapist is overall mentalizing capacity, denoting, in general, whether the client is good or poor at mentalizing without ascribing detail to that assessment.

parental reflective function: a parent's capacity to reflect upon his own and/or the child's internal mental experiences within the parent–child relationship as they manifest in parental descriptions of the ongoing, current, and evolving relationship to the child; critical for the optimal development of mentalizing capacity in children.

pedagogical intention: the intention to teach; often signaled through ostensive cueing.

prementalizing mode: there are three nonmentalizing modes that the therapist assesses: psychic equivalence, pretend mode, and teleological mode.

pretend mode: one of the prementalizing modes, which are considered developmentally appropriate in preadolescents but then should become a less dominant mode of thinking as mature mentalizing capacity develops; instances in which thoughts and feelings become severed from reality; thus, thoughts and beliefs are disconnected from authentic subjective and situated experiences in self and other; lack of authenticity and a disconnect between content and affect; "because I act it, it is true."

psychic equivalence: one of the prementalizing modes, which are considered developmentally appropriate in preadolescents but should become a less dominant mode of thinking as mature mentalizing capacity develops; in psychic equivalence, an individual believes that there is only one interpretation of reality—the one in his own mind; the individual struggles to see alternatives to subjective experience: he is certain and absolute in his thinking, with complete disregard for any evidence in support of his perspective; "because I think/feel it, it is true."

puts her mind on the table: denotes the process by which the therapist makes clear her intentions for communicating a particular piece of information; it denotes a transparency on the part of the therapist about what she is thinking, as well as signaling that her perspective and understanding may be different from that of the client.

reflective function: the quintessential human capacity to understand ourselves and others in terms of intentional mental states, such as feelings, desires, wishes, goals, and attitudes; often used as a synonym for mentalizing.

return to purpose: a concept that developed in the context of mentalization-based work in teams (e.g., AMBIT); making sure that the conversation surrounding a colleague's dilemma with a client stays on task so that a mentalizing solution can be found.

rewind: a technique often used in mentalization-based therapies where the therapist pauses in order to go back to a particular instance or utterance to established shared understanding over its meaning.

self and interpersonal function: Criterion A of the DSM-5 Section III definition of personality disorder identifies self and interpersonal function as the core of personality functioning—sometimes referred to as Level of Personality Functioning (LPF), which denotes a dimensional severity continuum characterized by the four domains of personality functioning: identity, self-direction, empathy, and intimacy.

serve-and-return: serve-and-return works like a game of tennis or volleyball between two interaction partners. One interaction partner "serves" by reaching out for interaction—with eye contact, facial expressions, gestures, babbling, touch, or language. The "receiver" will "return the serve"

by speaking back or engaging in some form of nonverbal behavior to acknowledge the serve, resulting in the server feeling understood.

slowing down: in essence, mentalization-based therapies are about slowing down the serve-and-return between interaction partners to negotiate and establish the shared meaning of what is going on, given that humans necessarily have unique and subjective experiences.

stating the case: a concept that developed in the context of mentalization-based work in teams (e.g., AMBIT); refers to telling the story that has created the context for the dilemma that a coworker needs help with.

subjectivity of human experience: refers to the emotional and cognitive impact of a human experience as opposed to an objective experience, which are the actual events of the experience. While something objective is tangible and can be experienced by others, subjective experiences are produced by the individual mind.

System 1 mental operations: automatic and often unconscious thinking involving mental short-cuts without evaluating the evidence in support of assumptions; often associated with implicit or affective mentalizing.

System 2 mental operations: controlled, deliberate, effortful, usually conscious.

teleological thinking: one of the prementalizing modes, which are considered developmentally appropriate in preadolescents but should become a less dominant mode of thinking as mature mentalizing capacity develops; if an adult engages in a predominantly teleological mode of thinking, he is considered to be nonmentalizing; teleological thinking involves concrete solutions to the problems of the mind—for example, needing the physical presence of a person to believe that she still loves you; focus on observable goal-directed behavior and objectively discernible events that may potentially constrain these goals; when a client requires worries or distress in the inner world to be resolved by visible, tangible outcomes in the physical world; "because I see it, it is true."

temperament: the early-appearing variation in reaction and emotional reactivity; forms the foundation for personality traits to develop in interaction with the environment; temperament may "pull for" certain behaviors from a parent, and children with difficult temperaments will require more from a caregiver's mentalizing capacity.

thematic coherence: the capacity to identify overarching themes, values, or principles that integrate different events in their life; it forms a critical part of the development of a consolidated identity during adolescence and young adulthood.

theory of mind: theory of mind (ToM) is an important social-cognitive skill that involves the ability to think about mental states, both your own and those of others.

therapist reorientation: incorporating a Mentalizing Stance into one's therapeutic work requires a therapist reorientation that entails abandoning an authoritative stance and embracing a not-knowing stance as therapist.

understanding and owning our own intentions: a characteristic of optimal mentalizing; being aware of one's own motivations and intentions and accepting their contribution in causing misunderstandings with another.

References

Allen, J. G. (2003). Mentalizing. *Bulletin of the Menninger Clinic, 67*(2), 91–112.

Allen, J. G., Fonagy, P., & Bateman, A. W. (2008). *Mentalizing in clinical practice*. Washington, DC: American Psychiatric Publishing.

Allison, E., & Fonagy, P. (2016). When is truth relevant? *Psychoanalytic Quarterly, 85*(2), 275–303.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: Author.

Andreou, C., Kelm, L., Bierbrodt, J., Braun, V., Lipp, M., Yassari, A. H., & Moritz, S. (2015). Factors contributing to social cognition impairment in borderline personality disorder and schizophrenia. *Psychiatry Research, 229*(3), 872–879.

Barlow, D. H., Farchione, T. J., Bullis, J. R., Gallagher, M. W., Murray-Latin, H., Sauer-Zavala, S., . . . Cassiello-Robbins, C. (2017). The unified protocol for transdiagnostic treatment of emotional disorders compared with diagnosis-specific protocols for anxiety disorders: A randomized clinical trial. *JAMA Psychiatry, 74*(9), 875–884.

Baron-Cohen, S. (2004). *The essential difference: Male and female brains and the truth about autism*. New York: Basic Books.

Baron-Cohen, S., Golan, O., Chakrabarti, B., & Belmonte, M. K. (2008). Social cognition and autism spectrum conditions. In C. Sharp, P. Fonagy, & I. M. Goodyer (Eds.), *Social cognition and developmental psychopathology*. Oxford, UK: Oxford University Press.

Baron-Cohen, S., Leslie, A. M., & Frith, U. (1985). Does the autistic child have a “theory of mind”? *Cognition, 21*(1), 37–46.

Bateman, A., Campbell, C., Luyten, P., & Fonagy, P. (2018). A mentalization-based approach to common factors in the treatment of borderline personality disorder. *Current Opinion in Psychology, 21,* 44–49.

Bateman, A., & Fonagy, P. (Eds.). (2012). *Handbook of mentalizing in mental health practice*. Washington, DC: American Psychiatric Publishing.

Beck, A., Freeman, A., & Davis, D. D. (2004). *Cognitive therapy of personality disorders*. New York: Guilford Press.

Bevington, D., Fuggle, P., Cracknell, L., & Fonagy, P. (2017). *Adaptive mentalization-based integrative treatment*. Oxford, UK: Oxford University Press.

Bo, S., Sharp, C., Fonagy, P., & Kongerslev, M. (2015). Hypermentalizing, attachment, and epistemic trust in adolescent BPD: Clinical illustrations. *Personality Disorders,*

Bo, S., Sharp, C., Kongerslev, M., Luyten, P., & Fonagy, P. (under review). Improving and expanding effective treatment for adolescents with borderline personality disorder: Toward a socioecological approach.

Bowlby, J. (1973). *Attachment and loss: Separation*. New York: Basic Books.

Bowlby, J. (1980). *Attachment and loss: Loss, sadness and depression*. New York: Basic Books.

Brune, M., & Brune-Cohrs, U. (2006). Theory of mind: Evolution, ontogeny, brain mechanisms and psychopathology. *Neuroscience and Biobehavioral Reviews, 30*(4), 437–455.

Carpendale, J. I., & Lewis, C. (2004). Constructing an understanding of mind: The development of children's social understanding within social interaction. *Behavioral and Brain Sciences, 27*(1), 79–96 (discussion, 96–151).

Caspi, A., Houts, R. M., Belsky, D. W., Goldman-Mellor, S. J., Harrington, H., Israel, S., . . . Moffit, T. E. (2014). The *p* factor: One general psychopathology factor in the structure of psychiatric disorders? *Clinical Psychological Science, 2*(2), 119–137.

Chanen, A., Sharp, C., Hoffman, P., & Global Alliance for Prevention and Early Intervention for Borderline Personality Disorder. (2017). Prevention and early intervention for borderline personality disorder: A novel public health priority. *World Psychiatry, 16*(2), 215–216.

Cicchetti, D., & Curtis, W. J. (2005). An event-related potential study of the processing of affective facial expressions in young children who experienced maltreatment during the first year of life. *Development and Psychopathology, 17*(3), 641–677.

Cicchetti, D., Rogosch, F. A., Maughan, A., Toth, S. L., & Bruce, J. (2003). False belief understanding in maltreated children. *Developmental Psychopathology, 15*(4), 1067–1091.

Cicchetti, D., & Toth, S. L. (2005). Child maltreatment. *Annual Review of Clinical Psychology, 1,* 409–438.

Cristea, I. A., Gentili, C., Cotet, C. D., Palomba, D., Barbui, C., & Cuijpers, P. (2017). Efficacy of psychotherapies for borderline personality disorder: a systematic review and meta-analysis. *JAMA Psychiatry, 74*(4), 319–328.

Csibra, G., & Gergely, G. (2009). Natural pedagogy. *Trends in Cognitive Sciences, 13*(4), 148–153.

Dennett, D. (1978). *The intentional stance*. Cambridge, MA: MIT Press.

Duncan, B. (2010). *On becoming a better therapist*: APA Press.

Dyck, M., Habel, U., Slodczyk, J., Schlummer, J., Backes, V., Schneider, F., & Reske, M. (2009). Negative bias in fast emotion discrimination in borderline personality disorder. *Psychological Medicine, 39*(5), 855–864.

Dziobek, I., Fleck, S., Kalbe, E., Rogers, K., Hassenstab, J., Brand, M., . . . Convit, A. (2006). Introducing MASC: A movie for the assessment of social cognition. *Journal of Autism and Developmental Disorders, 36*(5), 623–636.

Erikson, E. H. (1950). *Childhood and society*. W W Norton & Co

Fearon, R. P., Bakermans-Kranenburg, M. J., van IJzendoorn, M. H., Lapsley, A. M., & Roisman, G. I. (2010). The significance of insecure attachment and disorganization in the development of children's externalizing behavior: A meta-analytic study. *Child Development, 81*(2), 435–456.

Fluckiger, C., Del Re, A. C., Wampold, B. E., & Horvath, A. O. (2018). The alliance in adult psychotherapy: A meta-analytic synthesis. *Psychotherapy, 55*(4), 316–340.

Fonagy, P. (1989). On tolerating mental states: Theory of mind in borderline personality. *Bulletin of the Anna Freud Centre*.

Fonagy, P., & Allison, E. (2014). The role of mentalizing and epistemic trust in the therapeutic relationship. *Psychotherapy, 51*(3), 372–380.

Fonagy, P., Gergely, G., Jurist, E. L., & Target, M. (2002). *Affect regulation, mentalization, and the development of self*. New York: Other Press.

Fonagy, P., & Luyten, P. (2009). A developmental, mentalization-based approach to the understanding and treatment of borderline personality disorder. *Developmental Psychopathology, 21*(4), 1355–1381.

Fonagy, P., & Luyten, P. (2016). A multilevel perspective on the development of borderline personality disorder. In D. C. Cichetti (Ed.), *Developmental psychopathology* (Vol. 3, pp. 726–792). Hoboken, NJ: Wiley.

Fonagy, P., Luyten, P., & Allison, E. (2015). Epistemic petrification and the restoration of epistemic trust: a new conceptualization of borderline personality disorder and its psychosocial treatment. *Journal of Personality Disorders, 29*(5), 575–609.

Fonagy, P., Luyten, P., Allison, E., & Campbell, C. (2017a). What we have changed our minds about: Part 1. Borderline personality disorder as a limitation of resilience. *Borderline Personal Disord Emot Dysregul, 4,* 11.

Fonagy, P., Luyten, P., Allison, E., & Campbell, C. (2017b). What we have changed our minds about: Part 2. Borderline personality disorder, epistemic trust and the developmental significance of social communication. *Borderline Personal Disord Emot Dysregul, 4, 9.*

Fonagy, P., & Sharp, C. (2008). Treatment oucome of childhood disorders: The perspective of social cognition. In C. Sharp, P. Fonagy, & I. M. Goodyer (Eds.), *Social cognition and developmental psychopathology*. Oxford: Oxford University Press.

Fonagy, P., Steele, H., & Steele, M. (1991). Maternal representations of attachment during pregnancy predict the organization of infant-mother attachment at one year of age. *Child Dev, 62*(5), 891–905.

Frick, C., Lang, S., Kotchoubey, B., Sieswerda, S., Dinu-Biringer, R., Berger, M., . . . Barnow, S. (2012). Hypersensitivity in borderline personality disorder during mindreading. *PLoS One, 7*(8), e41650.

Frith, C. D. (1992). *The cognitive neuropsychology of schizophrenia*. Hillsdale, NJ: Erlbaum.

Gambin, M., Gambin, T., & Sharp, C. (2015). Social cognition, psychopathological symptoms, and family functioning in a sample of inpatient adolescents using variable-centered and person-centered approaches. *Journal of Adolescence, 45,* 31–43.

Gergely, G. (2008). Learning "about" versus learning "from" other minds: Natural pedagogy and the role of ostensive communicative cues in cultural learning in human infants. *International Journal of Psychology, 43*(3–4), 528–528.

Glimcher, P. (2003). *Decisions, uncertainty, and the brain: The science of neuroeconomics*. Cambridge: MIT Press.

Guyer, A. E., Silk, J. S., & Nelson, E. E. (2016). The neurobiology of the emotional adolescent: From the inside out. *Neuroscience and Biobehavioral Reviews, 70,* 74–85.

Ha, C., Sharp, C., Ensink, K., Fonagy, P., & Cirino, P. (2013). The measurement of reflective function in adolescents with and without borderline traits. *Journal of Adolescence, 36*(6), 1215–1223.

Happé, F. G. E. (1994). An advanced test of theory of mind: Understanding of story characters' thoughts and feelings by able autistic, mentally handicapped, and normal children and adults. *Journal of Autism and Developmental Disorders, 24*(2), 129–154.

Heinonen, E., & Nissen-Lie, H. A. (2020). The professional and personal characteristics of effective psychotherapists: A systematic review. *Psychotherapy Research, 30*(4), 417–432.

Jeung, H., & Herpertz, S. C. (2014). Impairments of interpersonal functioning: empathy and intimacy in borderline personality disorder. *Psychopathology, 47*(4), 220–234.

Juul, S., Simonsen, S., & Bateman, A. (2020). The capacity to end: Termination of mentalization-based therapy for borderline personality disorder. *Journal of Contemporary Psychotherapy, 50*(4), 331–338.

Kahneman, D. (2013). *Thinking, fast and slow*: Farrar, Straus and Giroux.

Karmiloff-Smith, A. (1992). *Beyond modularity: A developmental perspective on cognitive science*. Cambridge, MA: MIT Press.

Kernberg, O. (1967). Borderline personality organization. *Journal of the American Psychoanalytic Association, 15*(3), 641–685.

Kernberg, O. (1984). *Severe personality disorders: Psychotherapeutic strategies*. New Haven, CT: Yale University Press.

Kim, J., & Cicchetti, D. (2010). Longitudinal pathways linking child maltreatment, emotion regulation, peer relations, and psychopathology. *Journal of Child Psychology and Psychiatry, 51*(6), 706–716.

Kim, S. (2015). The mind in the making: Developmental and neurobiological origins of mentalizing. *Personality Disorders, 6*(4), 356–365.

King-Casas, B., Sharp, C., Lomax-Bream, L., Lohrenz, T., Fonagy, P., & Montague, P. R. (2008). The rupture and repair of cooperation in borderline personality disorder. *Science, 321*(5890), 806–810.

Klein, P. S. (1996). *Early intervention: Cross-cultural experiences with a mediational approach*. Oxford: Routledge.

Kruglanski, A. W., & Webster, D. M. (1996). Motivated closing of the mind: "Seizing" and "freezing." *Psychological Review, 103*(2), 263–283.

Lecours, S., & Bouchard, M. A. (1997). Dimensions of mentalisation: Outlining levels of psychic transformation. *International Journal of Psychoanalysis, 78,* 855–875.

Leslie, A. M. (1987). Pretense and representation: The origins of "theory of mind." *Psychological Review, 94*(4), 412–426.

Lieberman, M. D. (2007). Social cognitive neuroscience: A review of core processes. *Annual Review of Psychology, 58,* 259–289.

Lind, M., Vanwoerden, S., Penner, F., & Sharp, C. (2020). Narrative coherence in adolescence: Relations with attachment, mentalization, and psychopathology. *Journal of Personality Assessment, 102*(3), 380-389.

Lind, M., Vanwoerden, S., Penner, F., & Sharp, C. (2019). Inpatient adolescents with BPD features: Identity diffusion and narrative incoherence. *Personality Disorders: Theory, Research, and Treatment, 10*(4), 389-393

Linehan, M. M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford Press.

Lutz, W., Leon, S. C., Martinovich, Z., Lyons, J. S., & Stiles, W. B. (2007). Therapist effects in outpatient psychotherapy: A three-level growth curve approach. *Journal of Counseling Psychology, 54*(1), 32–39.

Luyten, P., & Blatt, S. J. (2011). Integrating theory-driven and empirically derived models of personality development and psychopathology: A proposal for DSM V. *Clinical Psychology Review, 31*(1), 52–68.

Luyten, P., Malcorps, S., Fonagy, P., & Ensink, K. (2019). Assessment of mentalizing. In A. Bateman & P. Fonagy (Eds.), *Handbook of mentalizing in mental health practice* (2nd ed.). Washington, DC: American Psychiatric Association Publishing.

Martinez, G., Alexandre, C., Mam-Lam-Fook, C., Bendjemaa, N., Gaillard, R., Garel, P., . . . Krebs, M. O. (2017). Phenotypic continuum between autism and schizophrenia: Evidence from the Movie for the Assessment of Social Cognition (MASC). *Schizophrenia Research, 185,* 161–166.

Marty, P. (1991). *Mentalisation et psychosomatique*. Paris: Laboratoire Delagrange.

Marty, P., & M'Uzan, D. (1963). La pensée opératoire. *Revue Francaise de Psychanalyse, 27,* 1345–1356.

McAdams, D. P. (2015). *The art and science of personality development*. New York, The Guilford Press.

Meins, E. (1997). *Security of attachment and the social development of cognition*. Hove, England: Psychology Press/Erlbaum (UK) Taylor and Francis.

Meins, E., Fernyhough, C., Fradley, E., & Tuckey, M. (2001). Rethinking maternal sensitivity: Mother's comments on infant's mental processes

predict security of attachment at 12 months. *Journal of Child Psychology and Psychiatry, 42*(5), 637–648.

Minzenberg, M. J., Poole, J. H., & Vinogradov, S. (2006). Social-emotion recognition in borderline personality disorder. *Comprehensive Psychiatry, 47*(6), 468–474.

Montag, C., Dziobek, I., Richter, I. S., Neuhaus, K., Lehmann, A., Sylla, R., . . . Gallinat, J. (2011). Different aspects of theory of mind in paranoid schizophrenia: Evidence from a video-based assessment. *Psychiatry Research, 186*(2–3), 203–209.

Morton, J. (1989, December 9). The origins of autism. *New Scientist.*

Nelson, E. E., Leibenluft, E., McClure, E. B., & Pine, D. S. (2005). The social re-orientation of adolescence: A neuroscience perspective on the process and its relation to psychopathology. *Psychological Medicine, 35*(2), 163–174.

Norcross, J. C., & Rogan, J. D. (2013). Psychologists conducting psychotherapy in 2012: Current practices and historical trends among Division 29 members. *Psychotherapy (Chic), 50*(4), 490–495.

Penn D. L., Sanna L. J., Roberts D. L. (2008). Social cognition in schizophrenia: an overview. Schizophr. Bull. 34, 408–411 10.

Penner, F., McLaren, V., Leavitt, J., Akca, O. F., & Sharp, C. (2020). Implicit and explicit mentalizing deficits in adolescent inpatients: Specificity and incremental value of borderline pathology. *Journal of Personality Disorders, 34*(Suppl. B), 64–83.

Peyroux, E., Prost, Z., Danset-Alexandre, C., Brenugat-Herne, L., Carteau-Martin, I., Gaudelus, B., . . . Franck, N. (2019). From "under" to "over" social cognition in schizophrenia: Is there distinct profiles of impairments according to negative and positive symptoms? *Schizophrenia Research: Cognition, 15,* 21–29.

Pfeifer, J. H., Lieberman, M. D., & Dapretto, M. (2007). "I know you are but what am I?!": Neural bases of self- and social knowledge retrieval in children and adults. *Journal of Cognitive Neuroscience, 19*(8), 1323–1337.

Premack, D., & Woodruff, G. (1978). Does the chimpanzee have a 'theory of mind'? *Behavior and Brain Sciences, 4,* 515–526.

Quek, J., Bennett, C., Melvin, G. A., Saeedi, N., Gordon, M. S., & Newman, L. K. (2018). An investigation of the mentalization-based model of borderline pathology in adolescents. *Journal of Comprehensive Psychiatry, 84,* 87–94.

Quek, J., Melvin, G. A., Bennett, C., Gordon, M. S., Saeedi, N., & Newman, L. K. (2019). Mentalization in adolescents with borderline personality disorder: a comparison with healthy controls. *Journal of Personality Disorders, 33*(2), 145–163.

Rogers, C. R. (1961). *On becoming a person: A therapist's view of psychotherapy.* London: Constable.

Ross, D., Sharp, C., Vuchinich, R., & Spurrett, D. (2008). *Midbrain mutiny: The picoeconomics and neuroeconomics of disordered gambling.* Cambridge, MA: MIT Press.

Sawyer, S. M., Azzopardi, P. S., Wickremarathne, D., & Patton, G. C. (2018). The age of adolescence. *Lancet Child and Adolescent Health, 2*(3), 223–228.

Schiefele, A. K., Lutz, W., Barkham, M., Rubel, J., Bohnke, J., Delgadillo, J., . . . Lambert, M. J. (2017). Reliability of therapist effects in practice-based psychotherapy research: A guide for the planning of future studies. *Administration and Policy in Mental Health, 44*(5), 598–613.

Sharp, C. (2014). The social-cognitive basis of borderline personality disorder: A theory of hypermentalizing. In C. Sharp & J. Tackett (Eds.), *The handbook of borderline personality disorder in children and adolescents (pp. 211–228)*. New York: Springer.

Sharp, C. (2016). Current trends in BPD research as indicative of a broader sea-change in psychiatric nosology. *Personality Disorders, 7*(4), 334–343.

Sharp, C., Barr, C., & Vanwoerden, S. (under review). Hypermentalizing: The development and validation of a self-report measure.

Sharp, C., & Fonagy, P. (2015). Practitioner review: Emergent borderline personality disorder in adolescence: Recent conceptualization, intervention, and implications for clinical practice. *Journal of Child Psychology and Psychiatry, 56*(12), 1266–1288.

Sharp, C., Fonagy, P., & Goodyer, I. M. (2006). Imagining your child's mind: Psychosocial adjustment and mothers' ability to predict their children's attributional response styles. *British Journal of Developmental Psychology, 24,* 197–214.

Sharp, C., Fonagy, P., & Goodyer, I. M. (2008). Introduction: Social cognition and developmental psychopathology. In C. Sharp, P. Fonagy, & I. M. Goodyer (Eds.), *Social cognition and Developmental Psychopathology.* Oxford: Oxford University Press.

Sharp, C., Ha, C., Carbone, C., Kim, S., Perry, K., Williams, L., & Fonagy, P. (2013). Hypermentalizing in adolescent inpatients: Treatment effects and association with borderline traits. *Journal of Personality Disorders, 27*(1), 3–18.

Sharp, C., & Kalpakci, A. (2015). Mentalization in borderline personality disorder: From bench to bedside. *Personality Disorders, 6*(4), 347–355.

Sharp, C., Kalpakci, A., Mellick, W., Venta, A., & Temple, J. R. (2014). First evidence of a prospective relation between avoidance of internal states and borderline personality disorder features in adolescents. *European Child and Adolescent Psychiatry.*

Sharp, C., Kulesz, P., Marais, L., Shohet, C., Rani, K., Lenka, M., . . . Boivin, M. (2021). Mediational intervention for sensitizing caregivers to improve mental health outcomes in orphaned and vulnerable children. *Journal of Clinical Child and Adolescent Psychology, 49*(4), 545–557.

Sharp, C., Pane, H., Ha, C., Venta, A., Patel, A. B., Sturek, J., & Fonagy, P. (2011). Theory of mind and emotion regulation difficulties in adolescents with borderline traits. *Journal of the American Academy of Child and Adolescent Psychiatry, 50*(6), 563–573.

Sharp, C., & Rossouw, T. (2019). Borderline personality pathology in

adolescence. In A. Bateman & P. Fonagy (Eds.), *Handbook of mentalizing in mental health practice* (pp. 281–300). Washington, DC: American Psychiatric Association Publishing.

Sharp, C., Shohet, C., Givon, D., Penner, F., Marais, L., & Fonagy, P. (2020). Learning to mentalize: A mediational approach for caregivers and therapists. *Clinical Psychology: Science and Practice, 27*(3), 1–17.

Sharp, C., & Vanwoerden, S. (2015). Hypermentalizing in Borderline Personality Disorder: A model and data. *Journal of Infant, Child, and Adolescent Psychotherapy, 14*(1), 33–45.

Sharp, C., Vanwoerden, S., & Wall, K. (2018). Adolescence as a sensitive period for the development of personality pathology. *Psychiatric Clinics of North America, 41*(4), 669–683.

Sharp, C., & Venta, A. (2012). Mentalizing problems in children and adolescents. In N. Midgley & I. Vrouva (Eds.), *Minding the child: Mentalization-based interventions with children, young people and their families*. London: Routledge.

Sharp, C., Venta, A., Ha, C., Schramm, A., Reddy, R., & Newlin, E. (2015a). First evidence for the link between attachment, social cognition and borderline features in adolescents. *Comprehensive Psychiatry, 24*(3), 283–290.

Sharp, C., & Wall, K. (2017). Personality pathology grows up: Adolescence as a sensitive period. *Current Opinion in Psychology, 21,* 111–116.

Sharp, C., & Wall, K. (2021). DSM-5 Level of personality functioning: Refocusing personality disorder on what it means to be human. *Annual Review of Clinical Psychology, 17,* 313–337.

Sharp, C., Wright, A. G. C., Fowler, J. C., Frueh, B. C., Allen, J. G., Oldham, J., & Clark, L. A. (2015). The structure of personality pathology: Both general ('g') and specific ('s') factors? *Journal of Abnormal Psychology, 124*(2), 387–398.

Shipman, K. L., & Zeman, J. (1999). Emotional understanding: A comparison of physically maltreating and nonmaltreating mother-child dyads. *Journal of Clinical Child Psychology, 28*(3), 407–417.

Slade, A. (2005). Parental reflective functioning: An introduction. *Attachment and Human Development, 7*(3), 269–281.

Sperber, D., Clement, F., Heintz, C., Mascaro, O., Mercier, H., Origgi, G., & Wilson, D. (2010). Epistemic Vigilance. *Mind and Language, 25*(4), 359–393.

Stern, D. N. (1985). *The interpersonal world of the infant*. New York: Basic Books.

Storebo, O. J., Stoffers-Winterling, J. M., Vollm, B. A., Kongerslev, M. T., Mattivi, J. T., Jorgensen, M. S., . . . Simonsen, E. (2020). Psychological therapies for people with borderline personality disorder. *Cochrane Database of Systematic Reviews, 5,* CD012955.

Vaskinn, A., Antonsen, B. T., Fretland, R. A., Dziobek, I., Sundet, K., & Wilberg, T. (2015). Theory of mind in women with borderline personality

disorder or schizophrenia: Differences in overall ability and error patterns. *Frontiers in Psychology, 6,* 1239.

Vygotsky, L. S. (1980). *Mind in society*. Boston: Harvard University Press.

Wampold, B. E., & Imel, Z. E. (2015). *The great psychotherapy debate: The evidence for what makes psychotherapy work* (2nd ed.): Routledge/Taylor & Francis.

Wimmer, H., & Perner, J. (1983). Beliefs about beliefs: Representation and constraining function of wrong beliefs in young children's understanding of deception. *Cognition, 13,* 103–128.

Index

Note. f, t, or b following a page number indicates a figure, table, or box.

Adaptive Mentalization Based Integrative Treatment (AMBIT), 178–179
Adolescence
- brain changes in, 49
- MBT and, 101–102, 103
- mentalizing development in, 42t, 49–52
- and onset of personality disorder, 80–82
- primary influences in, 49–50

Adolescent Mentalization-Based Integrative Treatment (AMBIT), 103
Adult-child interactions, as mediated learning experiences, 47–48
Affect elaboration, 160–163
- defined, 185
- MJ and, 161b–162b

Affect focus, 170–175, 171–173, 175
- defined, 185
- example of, 172–173
- MJ and, 173b, 175b

Affect mirroring, 57–58, 62, 64, 151
- defined, 185

Affect pyramid, 149, 149f
Affective mentalizing, 32–33
Agency
- defined, 185
- sense of, 51–52

Agentic learner, 61, 83
Alternative Model for Personality Disorder (AMPD), 10
Alternative realities, 16–17
Anna Freud National Centre for Children and Families (AFC), 181
Antisocial personality disorder (ASPD), mentalizing profile example, 97f
Assessment, 84–102
- key points in, 94–96
- measures for, 96
- of mentalizing polarities, 93–94
- mentalizing profile and, 84
- of mentalizing style, 92–93
- of overall mentalizing capacity, 85, 86t–87t, 87–88
- of prementalizing/nonmentalizing modes, 88–91, 92t

Associative coherence, 26–27
Attachment context
- mentalization development and, 52–57, 99
- and shift to learning, 57–59

Attachment disruption
- defined, 185
- epistemic trust and, 82
- mentalizing development and, 75–80

Attachment relationships, representations of, 52–53
Autism, hypomentalizing and, 72
Autism-spectrum disorders, *versus* BPD, 66
Automatic/unconscious thinking, 24–27, 25b

B

Balance
  holding, 131–134
  between mentalizing polarities, 67–68, 93–94
Baron-Cohen, Simon, 72
Bateman, Anthony, 22, 177
Bayesian modeling, 78
Bleiberg, Efrain, 57
Borderline personality disorder (BPD)
  biosocial theory of, 75
  case example of (*see* MJ's case example)
  comorbidity with, 6
  dimensional construct of, 8–9
  DSM-5 criteria for, 65–66
  and general factor of personality pathology, 65–66
  hybrid categorical-dimensional approach to, 65
  hypermentalizing in, 70–73, 93
  MBT structure and treatment trajectory in, 106–107, 108t–109t, 110
  mentalizing problems and, 64–68
  mentalizing profile example, 97f
  written formulation for, 110b–112b, 113
Bowlby, John, 52

C

Caregiver invalidation, mentalizing deficits and, 75–76, 76f
Caregivers
  internalization of, 63
  mentalizing and, 53–54
Causal coherence, 51
  defined, 186
Certainty
  defined, 186
  suspension of, 4, 105
Change
  Mentalizing Stance as driver of, 147 (*see also* Mentalizing Stance)
  transdiagnostic mechanism of, 14–15
Chimpanzees, ToM experiment and, 17–18
Choi-Kain, Lois, 182
Clarification, 157–160, 159b
  defined, 157
  with MJ, 159b, 160
Clark, Lee Anna, 9, 65
Client, marking/reinforcing mentalizing in, 145–147
Cognitive development, in adolescence, 50
Cognitive mentalizing, parts of, 31–32
Cognitive-behavioral therapy (CBT)
  mentalizing and, 32–33
  revolution of, 5–6
Comorbidity
  with BPD, 6
  in psychopathology, 74
Context
  interventions and, 149, 149f
  mentalizing and, 31, 34, 35
  nonmentalizing modes and, 94
  teleology mode and, 94
Contrary moves, 163–170
  goal of, 163
  MJ and, 164, 166b
  therapist experience and responses, 165t
Cultural factors, Mentalizing Stance and, 123

D

Deception, capacity for, 41t, 47
Dennett, Daniel, 18
Diagnostic and Statistical Manual of Mental Disorders (DSM-I), psychoanalytic orientation of, 6
Diagnostic and Statistical Manual of Mental Disorders (DSM-II), psychoanalytic orientation of, 6
Diagnostic and Statistical Manual of Mental Disorders (DSM-III), change in orientation of, 6
Diagnostic and Statistical Manual of Mental Disorders (DSM-V)
  change in orientation of, 6
  and formulation of BPD, 108t
Dimensionality, implications of, 8–9
Dopamine, as learning reward, 60

E

Early childhood, mentalizing development in, 41t, 46–48
Emotional factors, Mentalizing Stance and, 123

Empathic validation, 150–157, 152t, 153b
  defined, 186
  examples/counter-examples, 152t
  with MJ, 163–164, 163b
  proscribed statements *versus,* 152t.156
Empathy, *versus* sympathy, 16
Environmental factors, psychotherapy outcomes and, 13
Epistemic freezing, 78
Epistemic hypervigilance, 15
  defined, 186
Epistemic injustice, 82
Epistemic mistrust
  affective mentalizing and, 110, 111b–112b
  in end phase of therapy, 115
Epistemic trust, 63
  attachment disruption and, 78, 82
  defined, 59, 186
  development of, 59–61
  disruption of, 64
  as key change mechanism, 14–15
Erikson, Erik, 49
Evidence-based practice, limitations of, 7–8

F

False-belief paradigm, 18–20
False-belief task
  development and, 41t
  mind-reading and, 45
Felt sense of knowing, 118
Fonagy, Peter, 20, 22, 40, 68, 177
Frontolimbic system, changes in, 49

G

Gating system, 48
Gergely, George, 58
g-PD, of personality function, 10
Great Psychotherapy Debate (Wampold), MBT and, 5–8

H

Heuristics, defined, 187
Hypermentalizing
  affect arousal and, 150
  assessment of, 92
  in BPD, 70–73, 93
  defined, 69, 187
  examples of, 70b–71b, 92
Hypervigilance, epistemic, 15
Hypomentalizing
  assessment of, 92
  autism severity and, 72
  defined, 69, 187
  example of, 92

I

Imaginary audience phenomenon, 50–51
Implicit-automatic thinking; *see* System 1 thinking
Index of resilience, *p* factor and, 74
Infancy
  mentalizing development in, 41t, 43–45
  teleological thinking in, 77
Intentional mental states, 16
Intentionality, 16–17
  defined, 187
  therapeutic, 126
Interaction literacy, 167
  defined, 187
  enhancing, 118–119
International Classification of Diseases-11 (ICD-11), personality disorders in, 11
Interruptions, explaining intent of, 155–156

K

Kahneman, Daniel, 26
Kernberg, Otto, 10
Kissell, Robin, 182
Klein, Pnina, 47, 60, 189

L

Learning
  mentalizing's relationship to, 61
  and shift from attachment, 57–59
Learning experiences, mediated, 47–48
Leslie, Alan, 31
Level of Personality Functioning (LPF), 10–11, 51–52
Linehan, Marsha, 170

M

Magical thinking, 46, 79
Managed care movement, impacts of, 7

Marked mirroring, 62, 64, 151
Marking
  defined, 187
  to reinforce mentalizing, 107, 110b–112b, 145–147
Marking the task, 179–180
  defined, 187–188
Maternal mind-mindedness, 56–57
MBT structure, 103–116
  end phase in, 114–116
  psychoeducation and, 112–114
  treatment trajectory and, 106–107, 110
  written formulation in, 110b–112b
McAdams, Dan, 51
McLean Hospital, AFC-accredited training and, 182
Meaning-making, defined, 188
Mental operations, System 1 thinking, 24–27
Mental representation, defined, 188
Mental state language, increase in use of, 47
Mental states, intentional, 16
Mentalization-based therapy (MBT)
  additional training for, 181–182
  case of MJ and (*see* MJ's case example)
  classic training program for, 181
  components of, 1
  end phase of, 114–116
  generic therapeutic stance in, 2
  goal of, 1, 117
  Great Psychotherapy Debate and, 5–8
  and neglect of power, culture, discrimination, 125
  phases of, 106–107, 108t–109t
  power differentials and, 178
  slow acceptance of, 1–2
  structure of (*see* MBT structure)
  supervision and, 178–181
  termination formulation in, 116
  and working in teams, 178–181
Mentalization-Based Therapy for Adolescents (MBT-A), 101–102, 103
Mentalization-Based Therapy for Families (MBT-F), 103
Mentalizers, optimal qualities of, 36
Mentalizing
  absence of, 69 (*see also* Nonmentalizing modes)
  affective, epistemic mistrust and, 110, 111b–112b
  assessment of (*see* Assessment)
  and begetting mentalizing in client, 125–128
  cognitive *versus* affective, 31–33
  context and (*see* Context)
  defining, 16–17
  and flexibility of thought, 22, 24–31
  goals and values of, 34–38
  higher-order, 48
  history of, 17–24
  on internal *versus* external features, 33–34
  low emotional arousal and, 171–172
  marking/reinforcing in client, 107, 110b–112b, 145–147
  versus mind reading, 122, 126
  as multicomponent construct, 85
  versus nonmentalizing, example of, 37b–38b
  ostensive cueing in, 107, 110b–112b
  by parents/caretakers, 53–54
  published research on, 23f
  qualitative developmental shifts in, 81
  System 1 thinking and, 24–27
  System 2 thinking and, 27–31, 29b
  versus theory of mind, 2, 17–18
  therapist-client reciprocity in, 114
Mentalizing breakdown, assessment of, 91, 94–95
Mentalizing capacity, 85–88
  good *versus* poor examples of, 86t–87t, 87–88
Mentalizing comeback, 56
  defined, 188
  example of, 56b
Mentalizing development, 40–62
  attachment roots of, 52–57, 56b
  attachment to learning in, 57–59
  epistemic trust and, 59–61
  normative timeline for, 40, 41t–42t, 43–52 (*see also* Prementalizing modes)
Mentalizing difficulties, 63–83
  attachment-based, 75–80
  non-personality disorders and, 68–75
  personality challenges and, 64–68
Mentalizing errors, MASC and, 69
Mentalizing formulation, 84, 99–102
  defined, 188
  example of, 100b–101b

Mentalizing hand, 154–155, 158
Mentalizing impairment
  personality development and, 81–82
  psychopathology dimensions and, 73, 73f
  roots of, 73–75
Mentalizing Initiative, 182
Mentalizing interventions, 148–176
  context and, 149, 149f
  defined, 188
  level 1: empathic validation, 150–157, 152t, 153b
  level 2: clarification, affect elaboration, 157–163, 158f, 161f
  level 3: contrary moves, 163–170, 164f, 165t, 166b–167b
  level 4: mentalizing relationship, affect focus, 170–175, 173b, 174t, 175t
  spectrum of, 149–150, 149f
Mentalizing polarities, 34–38, 35f, 85
  balance between, 93–94
  defined, 188
  failure to balance, 67–68
  neural circuitries and, 68
  switching between, 95
Mentalizing process
  empathic validation in, 150, 151f
  narrative in, 119f, 121
Mentalizing profile, 96–99, 97f
  components of, 85
  constructing, 95
  defined, 188
  example of, 98b–99b
  as frame, 84
  for various disorders, 69
Mentalizing relationships, 170–175, 173b, 174t
  characteristics of, 175t
  MJ and, 173b, 175b
  steps in, 170–175, 174t
Mentalizing shortcuts, 54
Mentalizing Stance, 15, 83, 117–147
  versus authoritative stance, 3–4
  and avoidance of therapist pretend mode, 138–139
  and avoidance of therapist teleological mode, 139–141
  back and forth pattern in, 38
  defined, 188
  elements of, 127–147
    holding balance, 131–134
    inquisitive, open-source thinking, 128–130
    monitoring/managing arousal, 134
    not-knowing, 128
    terminating therapist nonmentalizing, 134–137
    therapist's use of self, 130–131
  epistemic trust and, 59
  examples of, 127
  factors affecting, 123
  going further with, 177–183
  learning, 2
  and monitoring/correction of therapist mistakes, 141–144, 144b–145b
  parental use of, 54–55
  from position, 122–124
  qualities of, 30
  role in understanding behavior, 103–105
  versus skills, 24
  and testing client limits, 95
  threat to, 91
Mentalizing style, 85
  defined, 189
Meta-cognition, transparency and, 110
Metarepresentations, 31–32, 33t
  defined, 189
Middle childhood, mentalizing development in, 42t, 48–49
Mind reading
  false-belief task and, 45
  versus mentalizing, 122, 126
Mind-blindness, 72
Mind-mindedness, maternal, 56–57
Mind-reading impairment, environment and, 74
Mirroring
  affect, 57–58
  parental, 57–58, 62, 136
MJ's case example
  affect elaboration in, 161b–162b
  clarification in, 159b
  contrary moves in, 166b
  empathic validation and, 153b
  mentalizing relationships and, 173b, 175b
  monitoring and correcting mistakes in, 144b–145b

MJ's case example (*continued*)
- narrative in, 105–106, 117–119, 143–144, 158, 160–162, 164, 166–169
- rupture repair in, 167b
- serve-and-return in, 119b–121b
- therapist owning up in, 168b–169b
- written formulation for, 110–112

Montague, Read, 20
Moral development, in middle childhood, 42t
Movie Assessment for Social Cognition (MASC)
- in mentalizing assessment, 96
- mentalizing errors and, 69

M-representations, 31–32, 33t

N

Narcissistic personality disorder (NPD), mentalizing profile example, 97f
Narrative identity, construction of, 81
Needs system, defined, 189
Neuroscience, social, mentalizing research and, 22, 23f, 24
Nonmentalizing, example of, 92
Nonmentalizing modes
- affect arousal and, 150
- assessment of, 92
- examples of, 89b–91b
- identification of, 77–78
- rigidity in, 78–79
- therapist experiences with, 92t

Not-knowing stance, 4
- defined, 189

O

Ostensive cueing, 14, 58, 107, 110b–112b
- defined, 189
- parental, 58, 151

P

p factor, scores on, 74
Parental mentalizing, disruption of, 64
Parental reflective function, 53–54, 61
- defined, 189

Parenting
- ostensive communication cues and, 58, 151
- pedagogical intention and, 58

Parents
- marked communication by, 59–60
- mentalizing and, 53–54
- Mentalizing Stance and, 54–55
- mentalizing *versus* nonmentalizing, 55–56

Pedagogical intention, 58
- defined, 189

Personality development, mentalizing impairment and, 81–82
Personality disorders; *see also* Borderline personality disorder (BPD)
- adolescence and onset of, 80–82
- in DSM-5, 9–11
- in ICD-11, 11
- mentalizing problems associated with, 64–68
- rethinking, 9–12
- underlying transdiagnostic features in, 11

Personality function, *g*-PD of, 10
Personality pathology
- general factor in, 9–10
- mentalization-based model of, 75–77, 76f

Piaget, Jean, 46
Power differentials, 178
- Mentalizing Stance and, 123–124

Premack, D., 17; *see also* Theory of mind (ToM)
Prementalizing modes, 40–52, 41t–42t, 85; *see also* Pretend mode; Psychic equivalence; Teleological thinking
- assessment of, 88–91, 92t
- defined, 190
- early childhood, 41t, 46–48
- infancy, 41t, 43–45
- intervention selection and, 77
- middle childhood, 42t, 49–52
- reversion to, 77
- rigidity in, 78–79
- summary of, 80
- toddlerhood, 41t, 45–46

Pretend mode, 61
- assessment of, 88–89
- defined, 190
- in end phase of therapy, 115
- examples of, 79–80, 88–89, 90b, 117
- in middle childhood, 42t, 49
- therapist responses to, 165t

Pretend play, 46

Psychiatric disorders, as dimensional *versus* categorical constructs, 8–9
Psychic equivalence, 2, 38, 41t, 61
  affect arousal and, 150
  assessment of, 88
  defined, 190
  examples of, 79, 88, 88b, 90b–91b, 117, 164
  interventions and, 77
  therapist response to, 165t, 169
  in toddlerhood, 46
Psychoeducation, 107, 108t, 112–113
Psychopathology
  general factor (*p* factor) for, 74
  practice manualization and, 3–4, 7–8
Psychotherapy, manualization of, 7
Psychotherapy outcomes
  common factors in, 12–13, 15
  extra-therapeutic factors and, 13
Putting mind on table, 14, 100, 107, 116, 148
  defined, 190
  R
Reality
  fixed views of, 148
  social construction of, 123
Reflective function, parental, 53–54, 61
Reflective Function Questionnaire for Youth (RFQY), in mentalizing assessment, 96
Relationships, mentalizing; *see* Mentalizing relationships
Resilience
  development and definition of, 63–64
  index of, *p* factor and, 74
Reward expectancy, 60

S

Sally-Ann task, 18–20, 19f; *see also* Theory of mind (ToM)
Schizophrenia, mentalizing errors in, 72
Sense of agency, in adolescence, 52
Serve-and-return, 5
  defined, 190
  mentalizing framework and, 118
  with MJ, 119b–121b
  slowing down and, 162
Slowing down
  defined, 191
  mentalizing hand and, 155, 158
  reflective capacity and, 119
  serve-and-return and, 162
Social emotions, in middle childhood, 48
Social factors, Mentalizing Stance and, 123
Social intelligence, gender and, 48
Social referencing, development of, 41t
Social signals, reading, 34
Stance, *versus* skills, 24
Supervisory conversations, structure of, 178–181
System 1 thinking
  characteristics of, 24–27, 30
  development of, 41t
  example of, 25b
System 2 thinking
  characteristics of, 27–31
  example, 29b

T

Teleological mode, 61
  assessment of, 89
  context and, 94
  defense function of, 169
  definition of, 44–45, 191
  development of, 41t, 44
  effective *versus* noneffective use of, 54
  in end phase of therapy, 115
  examples of, 79, 88b–89b, 89, 117
  functions of, 44–45
  in infancy, 77
  interventions and, 77
  therapist responses to, 165t
Temperament
  defined, 191
  definition and appearance of, 43–44
Termination formulation, 116
Thematic coherence, 51
Theory of mind (ToM)
  error types in, 69
  defined, 191
  experiment for, 17–20
  limitations of, 20
  versus mentalizing, 17–18
  mentalizing *versus,* 2
  second-order, 48
Therapeutic intention, 126

Therapist
  and avoiding mentalizing for client, 121–122
  essential qualities of, 12–13
  experiences with nonmentalizing modes, 92t
  mentalizing position of, 122
  and putting mind on table, 14, 100, 107, 116, 148
  reorientation in MBT, 3–5
  and repair of rupture, 167–170, 167b, 168b–169b
  required personality traits and, 4
  self-assessment by, 182–183
  and threat to holding Mentalizing Stance, 91
Therapist-client relationship
  affect focus in, 4
  collaborative nature of, 14
  impact of, 115
  mentalizing assessment and, 95–96
  power dynamics in, 124–125
  reciprocity in, 114
  therapist qualities and, 12–13
Thinking
  automatic, unconscious, 24–27, 25b
  controlled, deliberate, conscious, 27–31, 29b
  System 1 (*see* System 1 thinking)
  System 2 (*see* System 2 thinking)
"Thinking Together" team practice, 179
Thought, flexibility of, 22, 24–31
Toddlerhood, mentalizing development in, 41t, 45–46
Transparency; *see also* Putting mind on table
  meta-cognition and, 110
  therapist, 14
Treatment manuals, limitations of, 3–4, 7–8
Trust task, 20–22, 21f
  BPD and, 66–67
Tversky, Amos, 26

U

Unified Protocol for Transdiagnostic Treatment of Emotional Disorders (Barlow), 9

V

Values, Mentalizing Stance and, 123

W

Winicott, Donald, 128
Winnicott, Donald, 45
Woodruff, G., 17; *see also* Theory of mind (ToM)
Wright, Aidan, 9, 65