Fall 2017

Mentalization in counseling processes

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Mentalization in Counseling Processes

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A research project submitted to the Graduate Faculty of

JAMES MADISON UNIVERSITY

In

Partial Fulfillment of the Requirements

for the degree of

Education Specialist

Department of Graduate Psychology

December 2017

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Acknowledgements

I would like to offer my deepest gratitude to my wife Maria for her steadfast support, encouragement, and motivation throughout my graduate education. I could not have completed this graduate program without her, and am forever thankful for her generous kindness, patience, and understanding. I also want to acknowledge our daughter Lydia, who arrived on the scene in the midst of this thesis project. Lydia has opened my heart and mind to new depths and perspectives, and has forever changed how I will see the world. My family and friends have also been a huge encouragement as they've graciously demonstrated warmth, interest, and aid throughout my time in graduate school. My mother and father have been inspirational role models throughout this process, and have always emphasized the importance of perspective-taking, exploration, and curiosity throughout my life. Lastly, I want to acknowledge and offer my profound sense of appreciation to the members of my faculty committee – Dr. Eric Cown, Dr. Jennifer Cline, and Dr. Renee Staton. Their passions for counselor education have created a dynamic, engaging, and thought-provoking learning environment that has been deeply influential in my development as a counselor-in-training. I can confidently say Dr. Eric Cown, Dr. Jennifer Cline, and Dr. Renee Staton have helped to instill a sense of wonder and inquiry within myself that will continue to be invaluable as I grow and progress in the professional field of counseling.

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Abstract

The purpose of this literature review is to demonstrate the profound influences and numerous applications the concept of mentalization has within counseling processes. The skill of mentalizing extends across theoretical orientations within existing counseling frameworks and has been suggested to be a core factor within the counseling process (Allen, Fonagy, & Bateman, 2008). Mentalizing capacities have been linked to positive therapeutic alliances (Markowitz & Milrod, 2011), positive client outcomes (Bernbach, 2002; Bouchard et al., 2008; Fonagy & Target, 1996; Karlsson & Kermott, 2006; Levy et. al., 2006; Meehan, Levy, Reynoso, Hill, & Clarkin, 2009), and counselor effectiveness (Cologon, 2013); and as such is an essential skill for counselors and clients to develop.

Introduction

Mentalizing, synonymous with the operationalized term reflective functioning, is an essential concept within counseling and a crucial skill for clients to develop throughout the counseling process. Mentalizing can be defined as "imaginatively perceiving and interpreting behavior of oneself and others as conjoined with intentional mental states, shorthand for which is "holding mind in mind"" (Bateman *et al.,* 2012, p.514). Mentalizing involves our capacity to reflect upon our own experiences and internal working models, which are comprised of our memories, emotions, desires, intentions, and beliefs. Mentalizing increases our understanding of our own internal states, and our ability to hold other people's behavior and emotions in mind when considering their internal states. In other words, mentalizing capacities enable individuals to reflect upon their own feelings and thoughts and put them into words, and also helps people intuitively have a sense of other people's feelings (Freeman, 2016). Concrete examples of commonplace mentalizing include such instances as clients "considering the impact of relationships in the family of origin on current relationships" or "evaluating the accuracy of the clinician's observations and correcting the clinician's misunderstandings" (Allen, Fonagy, & Bateman, 2008, p.5). Within a psychoeducational client setting, Bateman et al. (2012) suggest describing mentalizing simply as *attending to the thoughts and feelings within yourself and others.*

Initially researched and developed by Fonagy and colleagues to treat clients with borderline personality disorder diagnoses, mentalization's scope within counseling has rapidly grown into an overarching counseling framework known as Mentalization Based Treatment (MBT) and has proven effective in treating other mental disorders such as antisocial personality disorder, eating disorders, depressive disorders, trauma related disorders, and addictive disorders

(Bateman et al., 2012). Mentalization's relationship to psychopathology is suggested as mutually influential. Psychopathology impairs mentalizing, and in possibly more nuanced ways, underdeveloped mentalizing capacities contribute to psychopathology (Allen, Fonagy, & Bateman, 2008).

Developed mentalization capacities allow for an individual's awareness of the representational nature of mind in relation to reality, encompassing both cognitive and affective life. Mentalization creates the possibility for reflecting on other perspectives and promoting flexibility. Mentalizing illuminates the awareness that others' actions are understandable when considering their underlying mental states and unique perspectives. This insight promotes a sense of self as a reflective mental agent in the world, and allows for the understanding of our unique subjectivity within our interpersonal contexts. Recognizing the opaqueness of other's mental states and emotions, mentalizing creates a not-knowing, inquisitive, and reflective stance that allows for the imaginative leap into the world of the other. Sustaining this mentalizing stance provides insights towards the inner workings of the self and other (Allen, Fonagy, & Bateman, 2008).

In treatment, through the counselor's contingently responsive, implicit and explicit mentalizing interactions, clients may temporarily borrow this representational capacity to enhance their own sense of self. Inherent within this mentalization process is the development of an increased sense of agency within the client, as they begin the process of knowing themselves more fully, and making themselves known (Allen, Fonagy, & Bateman, 2008).

The consequences of underdeveloped mentalizing capacities and undifferentiated modes of thinking lead to distortions in the perceptions of self and others (Freeman, 2016). It is suggested that most of psychopathology can be viewed as a reflection of either an inhibition of

mentalization or a failure to develop it in the first place. Counseling should be understood as an effort to kindle the client's mentalizing capacities, and as such should aim to ultimately promote a reflective mentalizing stance within the client that will allow the client to have flexible attention, openness to new information, and the ability to consider multiple perspectives on the same experience (Wallin, 2007).

Mentalizing can also be conceptualized as a core therapeutic factor that cuts across many forms of effective counseling regardless of theoretical orientation. In broadening our understanding of mentalizing and how it becomes disrupted, within ourselves and our clients, we strive to improve our therapeutic relationships and client outcomes within counseling.

The very experience of having our subjectivity understood – of being mentalized – is a necessary trigger for us to be able to receive and learn from the social knowledge that has the potential to change our perception of ourselves and our social world. (Fonagy & Allison, 2014, p.3).

In this sense, a mentalizing counseling stance provides the necessary environment for change to occur. To explore and illuminate the therapeutic process, the counselor must rely on their own mentalizing abilities to recognize not only the client's meaning making from their subjective internal working model, but also the counselor's meaning making in regards to their subjective internal working model; and how these two are contributing to the current counseling process and relationship. The term intersubjective or intersubjectivity refers to this collaborative relationship between two individuals' subjective realities.

<div align="center">Mentalization Polarities and Construct Comparisons</div>

The broad nature of the construct of mentalization adds to its appeal within the counseling profession but also may create confusion when compared to other overlapping constructs, such as theory of mind, mindfulness, empathy, and psychological mindedness. In an attempt to further understand the nature of mentalization and its relevance to the counseling profession, it is important to pull apart the nuanced differences between these various counseling constructs.

Before we can understanding the differences between these constructs, it is important to appreciate the four functional polarities within mentalization. These four polarities have been identified as related to relatively distinct neural systems through brain imaging studies of social cognition. Together they provide a comprehensive matrix for the conceptualization and assessment of mentalization and its distinction to various closely related constructs. The four polarities of mentalization include: automatic vs. controlled, internally focused vs. externally focused, self-oriented vs. other-oriented, and cognitive process vs. affective process (Bateman et al., 2012). The key to successful mentalizing is the integration of all four of these intersecting dimensions of mentalization into a coherent whole, maintaining an ability to use them flexibly according to circumstance or context. Assessing client's mentalizing capacities within these four dimensions provides valuable insights into potential clinical mental health concerns (Bateman, Bales, & Hutsebaut, 2014).

Controlled vs. Automatic Mentalization

Controlled mentalization, sometimes referred to as explicit mentalization, involves a relatively slow, deliberate process. Controlled mentalizing is typically verbal and requires conscious reflection, attention, intention, awareness, and sustained effort. One the other end of the spectrum, automatic or implicit mentalization is typically a reflexive process that requires

little to no attention, intention, or effort and often occurs just outside of our awareness. Both controlled and automatic mentalization processes are essential within intersubjective relationships, and an adaptive flexibility between these two poles demonstrate high levels of mentalization. Within the rapid speed of conversation and interpersonal interactions, particularly within attachment relationships, it is essential to rely on the intuitive and instinctual processes of automatic mentalization. The adaptive flexibility to switch to controlled mentalization is called upon typically when intersubjective interactions and relationships appear to be hampered. Instances such as a friend's sudden withdrawal from conversation or a child crying are times when automatic mentalizing must switch to controlled mentalizing as the individual becomes mindful, intentional, and reflective about the troubled intersubjective relationship (Bateman et al., 2012).

Much of counseling, regardless of theoretical orientation, involves challenging clients' maladaptive automatic mentalization processes. By inviting the client to enter into a joint process of reflecting on these automatic assumptions, and possibly distorted beliefs, we can improve the understanding of implicit processes and promote flexibility as automatic mentalization is brought into the realm of controlled mentalization. However, counselors must be mindful of the client's unique capacity to engage in this conscious reflection and controlled mentalization, particularly when intense emotional reactions are triggered. Many clients are unable to perform such controlled mentalization while experiencing high levels of emotional arousal. Individuals often default to automatic mentalization while under increasing levels of stress. When approaching a client's difficulties, it is essential for counselors to consider a client's emotional arousal level and capacity for automatic or controlled mentalizing within the therapeutic attachment relationship (Bateman et al., 2012).

Internally-focused vs. Externally-focused Mentalization

Internally focused mentalizing refers to the mental process of reflecting on one's own or another's internal world, such as thoughts, feelings, and intentions. In contrast, externally focused mentalizing relies on physical and visible features of one's own or another's actions, such as body language or facial expressions. This internal or external mentalizing may be either self-focused or other-focused, and in this way, is distinct from the self-other mentalizing polarity. A teleological stance, a mode of thinking pre-dating mentalization characterized by deriving understanding through concrete physical action, stems from the extreme end of the externally-focused pole. Individuals lapsing into a teleological stance may temporarily lose their mentalizing capacities and identify mental states only by action. An example of this may be self-harming behaviors.

High levels of mentalizing capacities are demonstrated by a balance between these two polarities such as the ability to consider the possible meaning of external behaviors, body language, or expressions through reflecting on the internal world of the self or other. Thus, the goal becomes linking both these external and internal features within the mentalization process. Within the counseling process, mentalizing interventions often start on an external level and then move on to generate possible perspectives about the subtleties and complexities of the internal states of clients' inner worlds. If a client's mentalizing capacities seem particularly inhibited, counselors may first need to take a pedagogic stance, educating clients on possible links between internal states of self and others based on external cues. This initial pedagogic stance helps to foster a client's awareness and ability to represent and reflect on future internal mental states. Clients struggling with somatization symptoms for example may feel oppressed in life while simultaneously displaying bodily representations of their oppression, such as a tightness of chest,

headaches, etc. For the client without adequate mentalizing capacities, these somatization symptoms may hold no link between the client's internal and external self (Bateman et al., 2012).

Self-oriented vs. Other-oriented Mentalization

Self-oriented mentalizing vs. other-oriented mentalizing refers to an individual's ability to represent and reflect on the internal and external worlds of the self or the other. The ability to feel and be aware of our behaviors, emotions, and thoughts, and translate other's emotions, thoughts, and behaviors into our own subjective reality provides intuitive insights for the observer into the inner life of the person observed. These self-other mentalizing polarities provide other-to-self and self-to-other tracking necessary in developing our understanding, or at times misunderstanding, within interpersonal relationships.

Examples of this process can be seen in the mirroring effects of the instinctual imitation of a conversational partner's gestures or the inclination to yawn after someone else yawns. The ability to inhibit this imitative behavior may be a key in instilling a sense of "me"-ness through identifying a "not-other"-ness and contain our own unique perspective. Within typical development, through reflecting on the intentions of others we gradually create a distinction between our own and other's experiences. This reflection and comparison of ourselves to others utilizes the self-oriented, other-oriented mentalizing polarities (Bateman et al., 2012).

In order to engage in other-oriented mentalizing, an individual must recognize that others have unique minds with desires, thoughts, and feelings that can be different from one's own. Ignoring these unique mental states that underpin other's behaviors and actions, an individual may temporarily collapse into a psychic equivalence mode of thinking. Within mentalization literature, psychic equivalence refers to a pre-mentalizing mode of thinking in which the

overvaluation of one's own perspective dominates mentalizing in regards to others. In psychic

equivalence, an individual may expect others to see situations in exactly the same way they do,

and may even become quickly frustrated when other's do not readily understand or share their

perspective. Rather than attributing this confusion to various points of view or alternative

perspectives, an individual in psychic equivalence mode may truly feel any misunderstanding

between self and others is intentional or even malicious on the part of the other (Busch, 2008).

Bateman et al. (2012) summarize this self-other mentalizing polarity:

Reflective mentalizing maintains self-other differentiation by enabling us to distinguish

our own and others' intentions and inhibiting the tendency for overly concrete experiences of

other people as if they were physically part of the self. (p.28).

Cognitive vs. Affective Mentalization

High levels of mentalizing capacities are marked by the integration of cognitions and

affects. Individuals giving undue weight to cognitive mentalization, such as clients with

narcissistic or antisocial personality features, may show considerable controlled cognitive

understanding of mental states but remain out of touch with the affective core of these

experiences. Individuals on the other end of the spectrum, such as clients with borderline or

histrionic personality features, may find themselves overwhelmed by automatic affective driven

mentalizing and lack the ability to integrate these affective experiences with more controlled,

reflective, cognitive knowledge. Interestingly, primarily affective mentalizing individuals may

tend to attribute their own internal states to others, in the sense of emotional-contagion, and may

demonstrate significant distress when confronted with sadness or pain in others. Contrast this

with genuine empathy in the face of other's suffering, and important clues for the assessment of

mentalizing capacities may be conceptualized through an individual's response to suffering or pain in others (Bateman et al., 2012).

Individuals acting on the extreme end of cognitive mentalization processes may demonstrate what is known as hypermentalization, a form of psuedomentalization, that mimics genuine mentalizing but lacks any real affective core, connection to reality, or resonance with underlying feelings. This hypermentalization, sometimes referred to as the defensive mechanism of intellectualization, can be a hallmark of the pre-mentalizing mode of thinking known as the pretend mode. Bateman et al. (2012) state the pretend mode, "…. is characterized by representational thought but unconnected to reality, manifest as freewheeling fantasies about internal states rather than genuine mentalization." (p. 30).

Different types of psychopathology may be characterized by an overemphasis on either cognitive or affective aspects of mentalization, and involve an impairment in the integration of the two. These deficits may appear through difficulties in naming, differentiating, and expressing internal states. Additionally, imbalanced mentalization on one of the four polarities described above will be evident in adults with personality disorders (Bateman et al., 2012).

Theory of Mind

Returning to the construct comparisons, theory of mind and mentalization share a considerable number of similarities. In many ways, the construct of mentalization has progressed and developed through theory of mind conceptualizations and research. Theory of mind is defined as the ability to realize that others have independent mental states, understand these mental states in others, and predict behaviors based on these mental states (Choi-Kain & Gunderson, 2008). In comparison to mentalization, theory of mind emphasizes primarily other

and cognitive dimensions, whereas mentalization strives for a balance between self-other and affective-cognitive dimensions. Although mentalization and theory of mind share a stance of understanding the mental states of others, mentalization based conceptualizations emphasize more process-oriented openness and curiosity whereas theory of mind based conceptualizations emphasize more product-oriented accuracy within understanding the mental states of others (Woynowskie, 2015).

Mindfulness

Mindfulness can be defined as being aware of and attentive to one's present experience nonjudgmentally (Woynowskie, 2015). Skills underpinning mindfulness involve observing, describing, acting with awareness, and accepting without judgement. Two domains within the construct of mindfulness can be conceptualized as attention regulation, and acceptance and openness to experience. "Both mindfulness and mentalization involve directing one's attention to one's own experience as a way to mitigate tendencies towards impulsivity and reactivity." (Choi-Kain & Gunderson, 2008, p. 1130). Both of these constructs also strive towards the integration of cognitive and affective parts of mental states while encouraging the simultaneous recognition and participation within the internal self-experience (Choi-Kain & Gunderson, 2008).

Mindfulness also involves cognitive flexibility in engaging and disengaging thought processes, mentally labeling observations, and distancing self from thoughts and feelings. Mindfulness incorporates elements of contemplation, imagination, and aims to enhance compassion towards self and others. Mindfulness' distancing of self from thoughts and feelings to gain perspective and acceptance overlaps with mentalizations emphasis on flexibility, curiosity, and openness towards internal mental states (Woynowskie, 2015).

In contrast to mentalization, mindfulness can be open to considering an individual's experience with inanimate objects instead of strictly interpersonal or intrapersonal. Mindfulness is also primarily oriented to the present experience, whereas mentalization may encompass the past, present, and future. Mentalization is also more concerned with constructing representations and meaning related to individual experiences, rather than the emphasis mindfulness places on the acceptance of internal experiences. Within the four polarities of mentalization discussed earlier, mindfulness shares similarities with the mentalization poles of the controlled mode, internal/external-focus, self-orientation, and cognitive/affective processes. However, mindfulness generally does not involve the mentalization poles of the automatic mode or other-orientation (Choi-Kain & Gunderson, 2008).

Empathy

Perhaps sharing the most overlap with mentalization is the construct of empathy. In refining the scales for assessing personality functioning for the DSM-5, the term mentalization was initially chosen, but ultimately substituted with the term empathy because mentalization was considered too unfamiliar and dependent on theoretical jargon. However, the definition of empathy in the DSM-5 remains closely tied to the concept of mentalization (Taubner, Hörz, Fischer-Kern, Doering, Buchheim, & Zimmermann, 2012). The DSM-5 defines empathy as, "comprehension and appreciation of others' experiences and motivations; tolerance of differing perspectives; understanding the effects of own behavior on others." (American Psychiatric Association, 2013, p. 821). Empathy involves emotionally resonating and reacting to another's affective state, emotional regulation enabling the distinction of the self-other origins of the affective state, and the cognitive capacity to imagine another's perspective (Woynowskie, 2015).

Empathy and mentalization both involve appreciation of mental states in others and can involve both controlled and automatic modes. However, empathy is more other-oriented while mentalization strives for both other- and self-orientations. Empathy also generally functions within the implicit or automatic mode, whereas mentalization aims for balanced automatic and controlled modes. Mentalization is equally cognitive and affective focused, whereas empathy is primarily concerned with the affective focus (Choi-Kain & Gunderson, 2008). Lastly, mentalization emphasizes more of a process of openness, curiosity, and reflection in comparison to empathy's emphasis on producing an accuracy in sharing another's mental state (Woynowskie, 2015).

<div align="center">Psychological Mindedness</div>

Psychological mindedness has been described as the ability to see connections between thoughts, feelings, and actions, and reflect on the motives, distortions, and inner-experiences of the self, and occasionally, in others. Psychological mindedness involves skills of recognizing cognitive and affective states within oneself and others, aimed at understanding behaviors. Both mentalization and psychological mindedness involve controlled (explicit) functioning, cognitive and affective focus, implicit and explicit features, and self- and other-orientations (Woynowskie, 2015).

Mentalization involves cognitive flexibility and oscillating between implicit and explicit orientations, whereas psychological mindedness emphasizes the explicit over an implicit orientation. Mentalization can occur whether one is conscious of the process or not, whereas psychological mindedness is geared towards understanding the meaning and relationship between mental states and behaviors, an inherently explicit process. For example, we implicitly mentalize as we respond to others' emotions by reflexively nodding sympathetically, or have a

gut reaction of uncomfortableness without yet switching to explicit mentalization to explore how

or why. However, psychological mindedness does not speak to this implicit dimension, and

refers rather to the deliberate and explicit process of understanding the connections between our

thoughts, feelings, actions, and our distortions, motives, or inner-experiences (Woynowskie,

2015). Additionally, psychological mindedness is primarily concerned with one's own mental

states, in contrast to mentalization's equal emphasis on self- and other-orientations (Choi-Kain &

Gunderson, 2008).

Theoretical Foundations

The psychological concept of mentalization was born out of the psychoanalytic and

object relations traditions, and has now flourished within attachment theory (Allen, Fonagy, &

Bateman, 2008). French psychoanalysts first introduced the term mentalization into the

psychiatric literature in the late 1960s, and later emphasized its essential role as "the 'immune

system' of the psyche" (Lecours & Bouchard, 1997, p.857). While the concept of mentalization

has been around for many decades, its development and implications for counseling have

progressed significantly within the last few decades. Because mentalization claims to be a core

counseling factor and transcend any specific theoretical orientation, it is important to understand

mentalizations' theoretical underpinnings in attachment theory and broader applications within

established treatments such as humanistic, cognitive-behavioral, and psychodynamic therapies.

Attachment Theory

Mentalization is an inherently developmental and intersubjective model. Mentalizing

capacities are developed within the context of attachment relationships -- ideally, secure

attachment relationships. Deficiencies in these mentalizing abilities are firmly rooted in

problematic affective responses of the primary attachment figure towards the child. Mentalization development is reliant on an attachment figure's adequate mirroring and provision of a secure base. In attachment literature, the concept of mirroring refers to the implicit, explicit, verbal, or non-verbal validation, acknowledgement, and empathic response to the child. The attachment figure serves as a secure base when the child knows their needs will be met, can reliably turn to the attachment figure when needing comfort, and feels safe exploring the world. With adequate mirroring and the attachment figure as a secure base, the child can then begin to integrate and understand their own emotional world in connection and contrast to the outside world (Freeman, 2016).

Bowlby, an early pioneer of attachment theory, characterized secure attachments as providing not only this secure base for exploration, but also a safe haven for emotional comfort and a felt sense of security. Bowlby, taking a developmental attachment model, considered a counselor's role as parallel to that of a parent who provides their child with a secure base from which to explore the world and take risks, and a safe haven to return when seeking comfort and security. Bowlby recognized that this attachment relationship provided a valuable platform not only for exploring the outer world, but also the inner world of the self (Allen, Fonagy, & Bateman, 2008). Summarizing what he believed to be a counselor's job, Bowlby stated:

> to provide the patient with a secure base from which he can explore the various unhappy and painful aspects of his life, past and present, many of which he finds it difficult or perhaps impossible to think about and reconsider without a trusted companion to provide support, encouragement, sympathy, and, on occasion, guidance. (Bowlby, 1988, p. 138).

Acquired early within the context of attachment relationships, the capacity to mentalize is considered a key determining factor for self-organization; including affect regulation and

attention control. In other words, the ability to understand the self as a mental agent is not a fixed genetic given but rather is fluid, developing out of interpersonal experience, particularly within primary object relationships. Mentalization's development is dependent on interactions with more mature minds that are benign, reflective, and sufficiently attuned to the child (Busch, 2008).

The Evolution of Mentalization

Taking an evolutionary developmental perspective, Fonagy argues that mentalization may be the evolutionary pinnacle of humans' mental accomplishment. Fonagy goes on to suggest that this evolution developed over time not to adapt to hostile forces of nature, but rather to deal with social competition. As the intellect of the competitive other increased over time, so too did the necessity for increasingly refined mentalizing abilities. Within this evolutionary competition conceptualization, the capacity to recognize that the mind governs actions and interprets or anticipates behavior, allows for cooperation and competitive advantages in increasingly higher levels of social interpretive functioning (Busch, 2008).

Because mentalization capacities are fluid and develop over time, attachment relationships have been deemed the gold standard for ensuring full development of the social brain. Attachment has been evolutionarily privileged as the primary facilitative relationship for mentalization to develop, likely because it is a vessel for genetic material, reciprocal relationships, and ideally altruism. The attachment relationship is preferably noncompetitive, where learning about minds can be safely practiced and enhanced. The capacity for mentalization, in addition to many other social-cognitive capabilities, evolve out of this safe, exploratory experience of social interaction with an attachment figure (Busch, 2008).

This approach to social development, particularly mentalization development, is in direct opposition to Cartesian assumptions that mental states are acquired through introspection. Mental states are discovered through contingent, and marked, mirroring interactions with an attachment figure (Busch, 2008). A child finds themselves in the attention from a caregiver, "I am, because you think of me." (Bateman et. al, 2012, p. 376). Rethinking the individualistic, intrapsychic drives model, this attachment framework calls for an intersubjective, social developmental perspective that is similar to psychoanalytic theories that place the ability to represent mental states symbolically as facilitated within the primary object relationship. From an attachment perspective, early disruption of affectional bonds not only sets up maladaptive attachment patterns, but also undermines a range of capacities vital to normal social development, such as mentalization capacities. In other words, understanding minds is increasingly difficult if an individual has no sense of what it is like to be perceived and understood as a person with a mind (Busch, 2008).

<center>Intergenerational Transmission of Attachment</center>

Mentalization and secure attachments have been found to be positively correlated, suggesting that parent's capacities to mentalize in the context of the attachment relationship facilitates the development of secure attachment in the infant, and thus also promotes the later development of mentalizing abilities in the child. A study conducted by Fonagy and colleagues linked a mother's capacity for mentalizing, to the attachment security and organization of their child. There is evidence to show that mothers' mentalization about their own earlier attachment relationships has important implications for their infant's attachment style. This supports the model of intergenerational transmission of attachment, and the mothers' mentalizing abilities serving as a protective factor for developing and promoting secure attachment relationships

(Berthelot, Ensink, Fonagy, Normandin, & Plamondon, 2016). These findings linking mentalization and attachment security and the intergenerational transmissions of attachment also have profound implications for an individual's future psychological health, and the counseling relationship.

<div align="center">Secure vs. Insecure Attachments</div>

As cited earlier, the parent's ability to mentalize the child likely serves to reduce the child's need to monitor the parent for trustworthiness and allows for a safe and relaxed interpersonal relationship fertile for the child to discover their psychological self in the world. When attachment systems are activated, often through some sufficient stressor or anxiety, higher brain functions such as mentalizing become inhibited. Insecure attachments are adaptive when intrapersonal resources, such as thinking about internal mental states, are limited and the child needs to monitor the unpredictable caregivers' mental states more carefully. However, this allocation of energy towards monitoring the unpredictable mental states of the caregiver deprives the child of the developmental learning opportunities found in more secure attachment relationships. When attachment figures adequately serve as a secure base and safe haven, children can free up their intrapersonal resources for exploration and developing full mentalizing capacities (Busch, 2008).

Within this attachment framework, secure attachment and attachment trauma are at the two extreme ends of the mentalization and attachment spectrum. Secure attachments facilitate the development of mentalization through the safe, exploratory relationship where the attachment system is activated less; allowing the child to be understood as having a mind while also exploring the mind of the caregiver. Caregivers with a secure attachment history are relatively adept at exploring their own minds and promoting an inquisitive stance towards the mental states

of their infant; allowing for a balance between awareness of the caregiver's own mental states to understand the infant without clouding any recognition of the child as an independent being. Secure attachments also strengthen an individual's capability to later retain a mentalizing stance even when attachment systems become activated by relational stressors. Secure attachments may be identified by a relatively increased capacity to generate coherent narratives of tumultuous interpersonal episodes (Busch, 2008).

On the other end of the spectrum, insecure attachment histories, particularly with attachment trauma, leave little room for mentalization to develop. Attachment trauma may create chronic activation of the attachment system, in which high levels of arousal, and fear of minds, create a terrorized and painful association with the exploration of the mental world. In attachment traumas, the child may instinctually inhibit mentalization development as a defensive and adaptive strategy. The child, attempting to seek protection from the malevolent and dangerous states of mind of the abuser, deactivates their capacity for awareness of mental states, at least within attachment contexts. In an extreme case, a vicious cycle may then be enacted through a child's unconscious proximity seeking to an attachment figure for physical and psychological care, fueled by the activated attachment system, only to leave the child further exposed to threat within the unsafe attachment relationship. In attachment trauma, the child is unable to use the model or mind of the other to understand him/herself, and thus diffusion of identity and dissociation may be the result (Busch, 2008).

The maturation of mentalization is undermined most within attachment traumas. Children missing the fertile relationships necessary for optimal development may not learn emotional language, and later in adulthood have difficulty recognizing facial expressions. Attachment traumas can create a lack of imagination about the mental worlds of others, demonstrated

through a cluelessness about what others think or feel, verging on confusion, or at times frustration. This underdeveloped mentalization capacity in the face of attachment trauma leaves the individual at risk of perpetuating the pre-mentalizing ways of being such as the psychic equivalence mode or pretend mode. Post-traumatic flashbacks for example, may feel all too real, and trigger this loss of awareness of the relationship between internal and external reality. Within psychic equivalence, survivors of trauma are likely to refuse to reflect upon their experiences because doing so means reliving it in a very real sense. Consider the immediacy of a memory experienced in a psychic equivalence mode and the potential or fear of re-traumatization. Individuals with attachment traumas may also enact a pretend mode, engaging in dissociated thinking and cutting off links between internal and external realities. An oscillation between psychic equivalence and pretend modes of experiencing the internal world is often characteristic of traumatization. The third pre-mentalizing mode, the teleological stance, may also be seen following attachment trauma. Verbal reassurances may mean very little to the individual experiencing trauma, and interacting with others at a mental level may be replaced by a teleological stance of only altering thoughts and feelings through actions (Busch, 2008).

Congruent and Marked Mirroring

The capacity to understand and regulate emotions, hallmarks of secure attachment, develops within the child when two conditions are provided by the caregiver. First, caregivers must demonstrate congruent mirroring that accurately matches the infant's internal states. Second, caregivers must display a marked difference of this mirroring, indicating that the caregiver is attune to the infant's internal states but not expressing their own genuine feelings of sadness, anger, or other difficult emotion the infant may be experiencing internally. This congruent and marked mirroring of the infant's internal states creates a pedagogical stance in

which the infant can learn about their internal world. Through congruent but marked mirroring the child can begin to create a sense of understanding without experiencing the caregiver's emotions as their own, and thus potentially indicative of the infant's emotions as being contagious or uncontrollable. This mirroring facilitates a process of responding in a manner that accurately acknowledges the child's mental state (congruent), and serves to modulate unmanageable feelings (marked). This conveys the caregiver's ability to contact the child's intolerable affect with a marked display indicating distance and coping. This congruent and marked mirroring process of affect regulation is thought to be internalized by the child to form the basis of a secure attachment bond and internal working model (Busch, 2008).

If mirroring is not adequately marked, a child may develop the intuition that their internal emotional world is overwhelming, uncontrollable, or contagious to others. When mirroring is continually and sufficiently not congruent with the child's internal state, the child is forced to accommodate mental states that feel contradictory, like a foreign or alien presence, within the child's self-representation. In extreme cases, these alien mental states within the individual's self-representation may become so unbearable that attachment behavior becomes focused on re-externalizing these parts of the self onto attachment figures. This re-externalization occurs when the child is left without the tools needed to internalize these mental states, within an integration process for containing affects and other self-states. In counseling theory, this re-externalization process is sometimes referred to as projective identification. Through projective identification, the painful and persecutory introjected parts of the self are externalized and experienced in the other; holding important clues within the counseling relationship for client's possible developmental arrests and how to further facilitate mentalization processes. Outside of a counseling relationship, projective identification may mirror processes, such as repetition

compulsions. The self, being disturbed from within by these alien mental states and identifying with the aggressor, enacts projective identifications that draw the other closer and selects relationships that will inevitably retraumatize. To escape from the cyclical nature of attachment traumas, the individual must seek help to recover mentalization capacities through a new, benign, secure attachment relationship (Busch, 2008).

This concept of congruent and marked mirroring also holds relevant parallels to the counseling process regarding the notion of a holding environment. In studying various videotaped short-term counseling sessions, researchers identified that more experienced and effective counselors showed less obvious facial affect (i.e., marked mirroring) in responding to clients than inexperienced or novice counselors (Bateman et al., 2012). As discussed earlier, attachment theory offers an explanatory conceptualization of why this congruent but marked mirroring is more effective in regulating emotions and avoids inhibiting mentalization through over activating the attachment system.

Additional parenting qualities have been found to be associated with the development of mentalization in children, such as: having discourse about emotions, depth of discussions involving affect, parents' beliefs about parenting, quality of parental control, and disciplinary strategies focusing on mental states (i.e., looking at the victim's feelings or the unintentional nature of transgressions). These parental qualities facilitate the integration and creation of mentalizing models for the child through complex linguistic and quasi-linguistic processes, that involve nonverbal and verbal aspects of social interaction, within an attachment context. With an experience-expectant brain, the child naturally turns to the caregiver to learn about the world, both internally and externally. Assumed to be primarily unconscious, the caregiver in turn continually ascribes a mental state to the child, influenced by their behaviors, implying the

child's mental agency. Ultimately, the child surmises that the caregiver's reactions to him/her make sense given the child's own internal state of belief or desires. This process, described throughout attachment theory, is considered to be mostly preconscious to both child and caregiver, and facilitates the development of a core sense of self organization or internal working model (Busch, 2008).

<div align="center">Mentalization's Developmental Timeline</div>

The emergence of mentalization capacities follow a developmental timeline through the means of secure attachments. Beginning at around 6 months of age, a child begins to construct causal relationships; connecting actions to their various agents and actions to the world. Infants around the age of 6 months can recognize animate objects as being self-propelled and can distinguish between natural and mechanical movement. Joint attention, social referencing, differentiating actions from their outcomes, and thinking about actions as a means to an end emerges around this time. By 9 months, infants begin to look at actions in terms of underlying intentions. This marks the beginning of the infant's teleological understanding of themselves as agents who can discover the most efficient way to achieve a goal from a range of choices. At this stage, agency is understood in terms of entirely physical actions or constraints. Staying in the teleological, physical, mode of thinking, the infant has no idea about the mental state of an object. The infant judges behaviors in terms of physical constraints or actions of the agent attempting to achieve a rational, physically observable goal. Reverting back to this pre-mentalizing teleological stance, adults may also sometimes find difficulty in accepting anything other than a change in the realm of the physical as a true indicator of the intentions of others (Busch, 2008).

During the second year of life, most children begin to develop a more mental understanding of agency. They can recognize themselves and others as intentional agents whose behaviors are influenced by states of mind, such as desires. During this time, children are also aware that their behaviors can influence changes in other's minds as well as their actions. Toddlers at fifteen-months can discern the differences between an action's intended and unintended consequences. At this stage of childhood, the capacity for emotional regulation begins to reflect the past and current attachment relationship with the primary caregiver. Within the second year of life, children begin to acquire language for their internal states, and the ability to reason non-egocentrically about feelings or desires in others. However, despite this drastic developmental leap forward, children at this age are not yet able to represent mental states independent of physical reality and cannot distinguish between their internal and external realities. Within mentalization literature, these pre-mentalizing stances are referred to as psychic equivalence, and the pretend mode. The pretend mode refers to a stance of internal reality being irrelevant in relation to an awareness of the physical world, sometimes carrying a dissociative quality when enacted later in life. Psychic equivalence refers to a stance of internal reality being equated and inflated as external reality. In psychic equivalence, the child assumes that their knowledge and internal world is shared and understood by all. Only later in their development does the realization of their own uniqueness of subjectivity create a differentiation between our mental self and other (Busch, 2008).

This move from psychic equivalence/pretend mode towards mentalization could be conceptualized as a developmental perspective on the narcissistic wound of Oedipus. In other words, we recognize that consciousness is not shared by all, and other minds may have different desires or intentions. (Busch, 2008). In linking psychoanalytic constructs, Holmes (2014) echoes

a similar sentiment, conceptualizing a positive oedipal experience as fostering a *third position*, that could arguably be called mentalizing. The oedipal experience, leaving the child momentarily alone and excluded from the parental dyad, allows the child a new painful freedom to develop thoughts and perspectives on their own, in a subjective and creative way. These uniquely developed thoughts and perspectives are referred to as a 'third position'.

During the third or fourth year, many children begin to understand agency in terms of mental causation, beginning to incorporate the representation of beliefs. The child at this age recognizes themselves as a representational agent, and understands that others do not always feel what they outwardly display as feeling. The child also begins to show emotional reactions to events influenced by the child's current mood, or even earlier emotional experiences linked to similar events. Creating structures to facilitate an emerging self-concept, children 3 or 4 years old, begin to understand that behaviors can be influenced by temporary mental states (i.e., thoughts and feelings), in addition to more stable characteristics (i.e., personality). In terms of mentalization development, children around this age take a considerable leap forward, recognizing and attributing mistaken beliefs to themselves or others. Interestingly, around this age children begin to prefer playing with peers instead of adults. This shift marks the beginning of the decline of mentalization acquisition primarily through the agency of the caregiver's mind. Thus beginning the lifelong phase of seeking to enhance mentalizing capacities through other intersubjective relationships with individuals who share one's interests and humor. The burden of responsibility and emphasis on the primary attachment relationship is dispersed, and teachers, neighbors, siblings, mentors, counselors, and friends can all join in this pedagogic curiosity towards the individual's subjectivity and optimize each other's capacities for mentalization. We

can only perceive and conceive of our mental states to the extent that the behavior of those around us have implied that we have them (Busch, 2008).

Finally, in the sixth year most children make additional advances in their abilities to integrate memories of their intentional behaviors and experiences into an increasingly coherent narrative, leading to the further establishment of a self. The child's experience of agency in interpersonal interactions can only emerge when behaviors can be recognized as influenced and directed by assumptions involving emotions, desires, and beliefs within both the self and other. At this age, children also add additional skills to their repertoire such as understanding mistaken beliefs about beliefs, understanding mixed emotions or being in conflict, how expectations might influence the interpretation of ambiguous events, and the capacity for more subtle forms of deception such as white lies (Busch, 2008).

To summarize this mentalization developmental time line, as the child ages, ideally they progress through the various pre-mentalizing modes, and ultimately arrive mentalization. First the child moves through the teleological mode where everything is driven by action and physically observable concrete understandings. Next, the child progresses to the psychic equivalence mode when internal reality is equated to external reality. The child then quickly balances this psychic equivalence with the pretend mode of internal experience not reflecting external reality and carrying no implications for the outside world. Finally, within this developmental time line, the child hopefully arrives at an integration of these various modes into a mentalizing mode. Within this mentalizing mode, mental states can be experienced as representations, linking inner and outer reality without equating these realities as equal nor dissociated them from each other (Busch, 2008).

Mentalization's Broader Application within Established Therapies

Counseling research has increasingly placed the relationship as the catalyst for change. This emphasis on relationship implicates the concepts of mentalization, and its connection to attachment research, as having profound and broad applications for various established therapies. Research demonstrates an existence of moderate and reliable links between positive therapeutic alliances and positive therapeutic outcomes, regardless of theoretical orientation, specific type of intervention, or therapeutic model. Some theorists even describe the quality of the therapeutic alliance as the standard unifying variable of a successful therapy (Wolfe & Goldfried, 1988). Within counseling literature, it is increasingly being accepted that regardless of theoretical orientation or counseling mode, attachment relationships between counselor and client, coupled with the collaborative desire to invest in the counseling process, are at the root of successful counseling outcomes (Ardito & Rabellino, 2011).

Humanistic Therapies

With this emphasis on the counseling relationship in mind, Holmes connects Buber's I-Thou construct (Buber, 1958) and mentalizing at the heart of a positive therapeutic alliance. Buber's I-Thou, in contrast to I-It, refers to the moment when two individuals meet in a fully intersubjective way, and is identified as an end in itself. This I-Thou meeting may be characterized by a spontaneous, present, authentic, encounter, where an individual is viewed within the entirety of their humanity. This is contrasted with Buber's I-It dichotomy where the individual is merely met as an object, without the notion of having a separate humanity or a mind of their own. In comparison, mentalizing may be thought of as possessing this I-Thou capacity to see both self and other as separate sentient beings, with unique desires, beliefs, and perspectives. This I-Thou capacity could arguably be conceptualized as developing within the context of sensitive parenting, as thoroughly referenced earlier within attachment theory. A mentalizing

adult is an I-Thou caregiver in relation to the child, able to differentiate their own thoughts and feelings from the child's, listening open-mindedly, and helping to co-regulate the child's emotions. Mentalizing caregivers foster mentalizing offspring and thus promote an intergenerational transmission of I-Thou relationships. Thus, mentalization provides grounded evidence for Buber's ethic of spontaneous, immediate, empathic, and accepting I-Thou relations (Holmes, 2011).

This authentic encounter and I-Thou meeting is central to humanistic counseling therapies. Carl Rogers, one of the founders of the humanistic approach to counseling, stated: "If I can provide a certain type of relationship, the other person will discover within himself the capacity to use that relationship for growth, and change and personal development will occur (Rogers, 1961, p.33)." Rogers believed this type of relationship was facilitated by the core conditions of empathy, congruence, and unconditional positive regard within the counselor. As discussed earlier, the construct of empathy and mentalization share many overlapping similarities. There are also significant overlaps between Roger's core conditions and the application and concept of mentalization within counseling processes (Cologon, 2013).

Humanistic counselors strive to encounter clients as more than the content of their thoughts, emotions, or histories. Third-generation cognitive-behavioral therapies (CBT), such as mindfulness and acceptance based CBT, emphasizes changing the client's relationship to their experiences instead of changing unwanted internal experiences. Psychodynamic therapists facilitate an attitude of curiosity and openness about the psychological states of self and others. All three of these established therapies share the common belief that clients benefit when the relationship to psychological content is altered, while affirming that the client is more than the content of their behaviors, thoughts, or emotions (Masterpasqua, 2016). This could be

conceptualized as best facilitated through the mentalization process and adapting a mentalizing stance.

Cognitive Behavioral Therapies

CBT's newer central emphasis on mindfulness creates several parallels to the construct of mentalization, as discussed earlier in comparing the two psychological constructs. Most notable, is the overlapping application between a mentalizing stance and CBT's mindfulness orientation of curiosity, openness, and acceptance towards one's immediate experience. Despite several differences, mentalizing and mindfulness are congruent therapeutic activities in regards to facilitating a curious, open, and accepting attitude. Researchers of mentalization-based therapies have even described mentalizing as *mindfulness of mind*, and explicitly compared mentalization to cognitive diffusion, a central process to CBT (Allen, 2009). CBT and mentalizing converge on the common ground of helping clients to experience curiosity, openness, and acceptance in the hopes of defusing them from undesired private experiences (Masterpasqua, 2016). Additionally, mindfulness-based approaches resemble mentalization based therapies because of the similar priority placed on process over content with the intent of fostering awareness of inner mental states and their impacts on individual's perceptions and interpretations. CBT systematically promotes mentalization through purposeful attention to automatic thoughts and dysfunctional attitudes, in turn fostering mentalizing about self and others (Bateman et al., 2012).

Psychodynamic Therapies

Bateman et al. (2012) also emphasize mentalization based therapies' origins within psychodynamic treatments. Psychodynamic treatments foster mentalization through the use of clarification, confrontation, and interpretation along with the exploration of maladaptive

representations of self and others within the context of the therapeutic relationship. The focus on

the transference relationship in psychodynamic treatments fosters self-other mentalization and

challenges client's implicit assumptions or relational enactments. The goal of this transferential

focus is to provide increased awareness through the exploration of the various functions or

meaning behind these assumptions concerning the counselor and other important relationships.

Like mentalization based therapies, psychodynamic therapies emphasize interpersonal

relationships, paying close attention to clients' object relations and attachments. Mentalization

based therapies mirror psychodynamic approaches with the intention that the primary instrument

of change is the intersubjective interactions between counselor and client (Katerud et al., 2012).

Utilizing transference, psychodynamic therapies aim to illicit and illuminate repetitive themes in

a client's interpersonal relationships using the here-and-now counseling relationship. This

recurrence of interpersonal themes in the counseling relationship provides unique opportunities

to explore and rework maladaptive patterns of attachment. The goal of psychodynamic therapies

echo mentalization's aims of greater flexibility in interpersonal relationships and an enhanced

capacity to meet interpersonal needs. Other themes of psychodynamic therapies that reflect

mentalization are the focus on client affect and expression of emotion, and the exploration of

clients' attempts to avoid distressing thoughts and feelings (Shedler, 2010).

Mentalization in Counseling Processes

Given mentalization's profound influences on the therapeutic relationship,

psychopathology, and counseling outcomes it is important to understand how mentalization

based treatment (MBT) is conceptualized and implemented generally, and within specific clinical

populations. Mentalization based treatment is described as occurring within the context of a safe,

reliable, and developing attachment relationship, where the counselor encourages the client to

remain involved in mentalizing processes through the exploration of each other's minds. The counselor remains attuned to the mentalizing abilities of the client by helping him/her regulate affects and by offering alternative perspectives for his/her experiences. Thus, two major goals within MBT are the establishment of a safe attachment environment, and the stimulation of a mentalizing process (Bateman, Bales, & Hutsebaut, 2014).

Fonagy and colleagues have identified "emotionally modulated conversations as the royal road to mentalizing" (Allen, Fonagy, & Bateman, 2008, p.105). As attachment systems are activated and affective arousal intensifies, mentalization often switches from a controlled, reflective, internally focused, and cognitively complex process, to an automatic, externally focused, emotionally intense process. Mentalization is a dynamic capability that is effected by stress and arousal, specifically within the context of attachment relationships. As emotions intensify within activated attachment systems, mentalizing is often inhibited. MBT's goal is to generate a safe and sensitive interpersonal environment that assists with the client's regulation of affect while enhancing his/her focus on mentalizing (Bateman et. al, 2012). The ability to maintain a mentalizing stance while emotionally activated is the gold standard of mentalization. "…mentalizing in the emotionally charged context of a psychotherapeutic relationship is not just hard work; it is *the* work." (Bateman et. al, 2012, p. 381). Interestingly, mentalizing typically generates more mentalizing while non-mentalizing generates non-mentalizing, making it all the more challenging for the counselor to mentalize in the face of non-mentalizing clients (Allen, Fonagy, & Bateman, 2008).

MBT adheres to a here-and-now focus, and only considers exploration of the past as it pertains to current mental states. MBT does not focus on causal explanations or insights, but rather aims to promote meaningful narratives within the midst of emotional states. Comparing

the counselor to an infant-minded parent, similarities are found to the extent of promoting

mentalizing within a caring relationship:

> Employing attention and imagination, we must develop accurate and rich mental
>
> representations, always open to novel elaborations while remaining mindful of skewing
>
> preconceptions and countertransference distortions. Psychotherapy is indeed a
>
> pedagogical relationship insofar as it is characterized by contingently responsive, implicit
>
> and explicit mentalizing interactions in which our patients can make use of our
>
> representational capacity to enhance their sense of self; inherent in this process is
>
> enhanced agency stemming from the process of knowing oneself and making oneself
>
> known. (Allen, Fonagy, & Bateman, 2008, p.111).

<center>Mentalizing the Transference</center>

Counseling within MBT is an inherently interpersonal process, and often reactivates an

attachment system that creates emotionally challenging experiences for clients, particularly those

with insecure/disorganized attachment histories. As counselors demonstrate unconditional

positive regard, empathy, and congruent and marked mirroring towards the client, the attachment

system will inevitably become activated. When the attachment system becomes too activated

however, mentalizing diminishes, and early insecure relationship patterns begin to permeate the

client's mind and color the experiences of the counseling relationship. Pre-mentalizing modes of

thinking may become dominate, such as teleologically motivated enactments within the

therapeutic relationship. Within the psychic equivalence mode, misperceptions may be

experienced as if real in the non-mentalizing transferential milieu of the overly activated

attachment system. MBT calls on counselors to be aware of this interpersonal process and these

potential enactments within non-mentalizing modes of thinking. MBT emphasizes a counselor's

keen awareness of moment-to-moment changes in the client's mental state, so as to be ready to hit the pause button, step back, and reflect on maladaptive relationship enactments within the here-and-now of an overly activated attachment system. Within MBT, this focus towards transferential enactments and non-mentalizing modes of thinking within the therapeutic relationship is called mentalizing the transference (Bateman et. al, 2012).

Mentalizing the transference in MBT is understood using a metaphor of sitting side by side with the client discussing thoughts and feelings, and both taking an inquisitive position towards the process. Once an enactment of non-mentalizing modes of thinking within the current therapeutic relationship is recognized, mentalizing the transference intervenes along the following steps: 1) validating the experience, 2) non-defensively accepting and exploring the enactment in the current here-and-now relationship, including an honest assessment of the counselor's own contributions/distortions, 3) collaboratively arriving at a mutual understanding while presenting alternative perspectives, and 4) closely monitoring and exploring client's reactions to the new understanding (Bateman et. al, 2012).

Some common countertransference experiences have been identified and may be useful in alerting counselors of potential enactments within the current therapeutic relationship. Pretend mode enactments may illicit countertransferential experiences within the counselor of feeling bored, perceiving client statements as trivial, feeling rigid, flat, or operating as if on autopilot. Teleological process enactments may illicit counselor countertransference of wishing to do something, making lists, offering concrete coping strategies, or giving practical advice. Psychic equivalence enactments may leave counselors feeling puzzled or confused, nodding excessively, not being sure what to say, or feeling angry with the client. These countertransferential experiences are considered the counselor's own marked experience and not necessarily a result

of projective identification. Thus, MBT encourages counselors to exercise clinical judgement and use "I" language within interventions highlighting countertransference. In promoting mentalization, clients need to become aware that their mental processes have an effect on others' mental states and, in turn, will affect interpersonal interactions. The counselor's disclosure of their own underlying feeling, when done non-defensively, sensitively, and carefully marked, can be a useful tool to extend the therapeutic alliance and model a mentalizing stance (Bateman et. al, 2012).

<div align="center">Optimal Activation</div>

MBT can be conceptualized as following a general process of oscillating between promoting a mentalizing stance through a secure attachment relationship, and mentalizing the transference when the counseling relationship hyperactivates the attachment system. Deliberate and purposeful activation of the attachment system is necessary within this counseling process as the MBT counselor strives to balance mentalizing and attachment within optimal emotional arousal. Following the principle that high arousal states suggest the counselor needs to provide interventions to deactivate attachment system, MBT recommends making contrary moves to achieve this optimal balance. Contrary moves within MBT refers to a switch in focus between mentalization polarities, such as moving from self-oriented talk to other-oriented talk or from an affect-focus to a cognitive-focus. An ideal, optimally balanced activation of attachment feelings, through an empathic and attuned counselor, facilitates a brain state within the client that reduces the influence of constraints on understanding the present by way of the past. Thus, within this optimal activation, the attachment environment creates the possibility of rethinking and reconfiguring interpersonal relationship patterns. This balanced activation of the attachment system mediates critical thinking about the present, but may be readily compromised if the

attachment system becomes hyperactivated. When hyperactivated, MBT calls for the counselor to then hit the pause button, step back, reflect, and attempt to recover the mentalizing process. In general, when the client is actively involved in treatment, the overall aim of MBT can be thought of as simultaneously stimulating the client's attachment while helping the client to maintain mentalization (Bateman et. al, 2012).

<div align="center">A Mentalizing Stance</div>

To promote curiosity within clients about the way mental states motivate and explain actions, a counselor must model and practice what MBT calls a mentalizing stance within the counseling relationship. A mentalizing stance is one of an inquisitive, not-knowing attitude that highlights the counselor's interest in mental states underlying behaviors and aims at not making assumptions but rather asking for clarification to gain better understanding. A mentalizing stance recognizes an individual's subjectivity and respects the opaqueness in mental states, appreciating the limitations of our own mentalizing abilities, and relying on the client to articulate and express their own unique experiences and perspectives. Within this not-knowing attitude, words or phrases such as "must", "just", "clearly", "obviously", or "only" should be avoided by MBT counselors. Ideally, a counselor's mentalizing stance should include the following aspects:

> Maintaining humility derived from a sense of not knowing, taking time to identify differences in perspectives whenever possible, legitimizing and accepting different perspectives, actively questioning the patient about his or her experience, asking for detailed descriptions ("what" questions) rather than explanations ("why" questions), and eschewing the need to understand what makes no sense (i.e., saying explicitly that something is unclear). (Bateman et. al, 2012, p.41).

An important aspect of a mentalizing stance is actively monitoring and acknowledging one's own mistakes as the counselor. This calls for honesty, authenticity, and courage, while providing invaluable opportunities for exploration of how mistakes may occur out of incorrect assumptions about opaque mental states. Additionally, insights may be gained for how misunderstandings may then lead to hostile interpersonal experiences. Because non-mentalizing begets non-mentalizing, it is essential for the counselor to be aware of their own internal processes and alert to the risk of losing the capacity to mentalize in the face of the non-mentalizing client. When mentalizing is lost by counselor and client, problematic enactments within the therapeutic relationship are often the result (Bateman et. al, 2012).

MBT Goals and Process

Steeped in attachment theory, MBT is a relational approach that places priority on interpersonal concerns. As such, MBT aims to promote a spirit of mentalizing within the counseling relationship, framed as a process, or way of being. In emphasizing this process-orientation, MBT does not provide a formalized manual of specific techniques and structured interventions. However, given the depth of research, extensive clinical experiences, and thorough exploration into mentalizing processes, Fonagy, Bateman, and colleagues have identified various aspects of treatment that have been found to promote mentalization. Overarching goals within MBT are to achieve, enhance, and stabilize mentalizing in the context of the attachment relationship, recover mentalizing at any point it is lost, minimize the chance of adverse effects associated with non-mentalizing interventions, and allow clients to discover themselves through the mentalizing process of consistently having their mind in mind (Allen, Fonagy, & Bateman, 2008). To achieve these goals, the counselor provides tailored interventions along the following continuum, moving from least emotionally activating to most activating within the attachment

system: 1) supportive, empathic, clarification, elaboration interventions, 2) challenging interventions aimed at interrupting client's non-mentalizing flow and opening a window for mentalizing to restart, 3) affect focused interventions, particularly the current affect shared between client-counselor relationship, and 4) mentalizing the transference, engaged in exploring interpersonal processes (Bateman et. al, 2012).

        With the therapeutic alliance securely in place, the MBT counselor consistently monitors mentalizing processes, transference/countertransference, and creates interventions that unfold along the following steps: 1) identifying breaks in mentalizing, indicated by non-mentalizing modes of thinking such as psychic equivalence, pretend mode, or teleological understanding, 2) ask client to "rewind" to moment before the break in mentalizing occurred, 3) explore current emotional context possibly contributing to the break in mentalizing by identifying the momentary affective state between client and counselor, 4) explicitly identifying and owning any contribution to this break in mentalizing that may be coming from the counselor, and 5) help client understand the mental states implicit in the current state of the client-counselor relationship, i.e. mentalize the transference. This intervention process is also referred to as the mentalizing functional analysis within MBT and follows several basic operations. First, the counselor explores the content of the event precipitating the collapse in mentalizing, and explores what was going on in the client's mind before the event took place. Next, the counselor collaboratively looks at the motivation or function of the action, and any positive/negative consequences of the reaction. Inherent within this mentalizing functional analysis process is the attempt to understand the emotions that the lapse in mentalization produces for the client, and exploring what kind of non-mentalizing mode the client used. The mentalizing functional analysis is established on the idea that emotions are created by interactions with others and

rooted in the interpretations of these interactions. Understanding the process of how this occurs

for the client allows mentalizing to be maintained within future interpersonal interactions. To

maximize the client's ability to consider thoughts and feelings in relationship contexts,

counseling interventions are most beneficial when they are: simple/easy to understand, affect

focused, actively engage the client, focus on client's mind rather than behavior, relate to current

felt mental reality, make use of the counselor's mind as a model, and flexibly adjust complexity

and emotional intensity in response to client's emotional arousal/attachment activation (Bateman

et. al, 2012).

<center>"Good" Mentalizing</center>

In attempting to recognize what good mentalization looks like, Bateman, Bales, and

Hutsebaut (2014) have created an informal assessment of mentalizing traits within four themes

of an individual's mentalization process. The profile of what characterizes good mentalization is

outlined in the following table.

<center>Table 1: Profile of Good Mentalization (Hutsebaut, 2014)</center>

Mentalization in relation to other people's thoughts and feelings	Mentalization regarding perception of own mental functioning
• acknowledging opaqueness of mental states • absence of paranoia • contemplation/reflection • perspective-taking • genuine interest in other's thoughts/feelings • openness to discovery • forgiveness • predictability given knowledge of what others think/feel	• changeability • developmental perspective • realistic skepticism • acknowledgment of possible preconscious operations • awareness of incompatible ideas/feelings • self-inquisitive stance • interest in different perspectives • awareness of the impact of affect

Mentalization in regards to self-representation	Mentalization with regards to general values and attitudes
• advanced pedagogic and listening skills • autobiographical continuity • rich internal life	• tentativeness • balance/moderation

Mentalization Based Treatment for Eating Disorders

To illustrate clinical practices of MBT, it is helpful to apply the general principles of MBT discussed above to more specific clinical populations, such as clients meeting diagnostic criteria for eating disorders. MBT proposes disordered eating indicates severe impairments in mentalizing capacities. Disordered eating through an MBT lens is conceptualized as connect to insecure attachment classifications, and should be thought of as a manifestation of an underlying disorder of the self- and affect-regulation. MBT understands symptoms of eating disorders as an attempt to drown out overwhelmingly painful self-states with frantic self-stimulatory activities. Eating disorder symptoms may be considered maladaptive attempts to organize emotions and other internal states. From a MBT framework, this bodily attempt to organize internal states is called embodied mentalizing. Embodied mentalizing suggests that the body may at times fill in during moments of mentalizing failures. Ultimately, MBT is more concerned with client's mental representations as a process rather than on the exploring insight and meaning behind symptoms. MBT places emphasis on how mental functioning is impaired as opposed to why (Bateman et. al, 2012).

From a developmental attachment perspective, the creation of an agentive self is solidified through the contingent mirroring and attribution of mental states that emerges through interactions with the caregiver in the context of attachment relationships. Disordered eating may

be conceptualized as arising out of the caregiver's misinterpretations of the infant's nonverbal, pre-symbolic communications, and a direct mislabeling of the child's feeling state. Examples of this may be repeatedly incorrectly labeling the child as being hungry, cold, tired, etc. regardless of the child's own experience. Such consistent incongruent mirroring, if significant enough, may lead the child to develop a mistrust in the legitimacy of their own feelings and experiences. Thus, individuals with disordered eating may be conceptualized as individuals who do not know because they have not learned to distinguish. Symptoms of eating disorders may readily provide the adaptive function of compensating for deficits in control, a sense of identity, competence/effectiveness, and the containment of bewildering emotions (Bateman et. al, 2012).

Psychic equivalence within clients diagnosed with eating disorders is considered the bodily concretization of inner reality. In other words, being thinner is felt to be superior, and therefore is superior. In psychic equivalence, unmentalized mental states do not achieve representational status, and come to be represented in the bodily domain. Physical attributes come to reflect internal states such as a sense of self-worth, control, or overall well-being. Thus, individuals with eating disorders unable to control overwhelmingly painful emotions may experience these painful emotions as a somatic bodily sensation, perceiving the self as getting bigger or fatter. In turn, client's psychic equivalence of an "is" quality may create difficult interpersonal dynamics within the counseling relationship as the counselor works to promote mentalization and engage an "as if" representational quality (Bateman et. al, 2012).

The non-mentalizing pretend mode may be seen in clients with eating disorders who identify a felt sense of their body as not being their own. Clients' descriptions of their body as a sort of alien shell outside themselves carry the dissociative qualities of the pretend mode affecting both emotions and bodily sensations. This pretend mode may serve to cover feelings of

emptiness and/or meaninglessness and create an alternative to psychic equivalence by decoupling internal reality from external reality. The pretend mode adaptively creates disembodied states disconnected from both overwhelmingly painful affects and somatic stimuli (Bateman et. al, 2012).

A teleological stance may also become readily apparent when working with clients diagnosed with eating disorders, as clients seek to achieve changes within their inner self through physical means. Overwhelming self-states become concretized and regulated through physical action, and bodily rituals may come to hold a multitude of symbolic meanings within a teleological stance. One client diagnosed with an eating disorder and engaged in MBT summarized her previous teleological stance as, "I gradually understood that taking control over food was a way to take control over my overwhelming worries, my restlessness, all my anxieties about myself, and simply my need to be somebody." (Bateman et. al, 2012, p. 356).

The goal of MBT for eating disorders is to help clients mentalize the body. In stimulating the client's exploration into their concrete experiences with body and food, the MBT counselor strives to connect them to emotional, cognitive, and relational experiences. In connecting these concrete experiences of body and food to internal states, the MBT counselor hopes to help translate these experiences into a language that reflects both a physical reality and a representational metaphor for mind. In this way, the MBT counselor attempts to bridge the gap between primary affective experiences and their symbolic representations, while identifying and challenging psychic equivalence thinking. Special attention is placed on triggers for bodily feelings, aiming to identify subtle changes in mental states that may unsettle the client physically as well as psychologically. Increased mindful awareness of bodily sensations promotes the likelihood of identifying and mentalizing these triggers. Ultimately, MBT hopes to provide

clients with an explicit and systematic focus on improving and utilizing the therapeutic alliance by generating trust and promoting autonomy, while repairing ruptures along the way through recovered mentalizing. MBT encompasses a deep respect for a variety of different perspectives on oneself, others, and the rest of the world, promoting flexibility, and attempting to create and engage an attitude of "playing with reality". MBT aims to stimulate self-development through attending to the client's thoughts and feelings, paralleling attachment interactions between infant and caregiver (Bateman et. al, 2012).

Mentalization Based Treatment for Depressive Disorders

An MBT perspective places depressive disorders as rooted primarily within impairments in mentalizing capacities, which in turn are grounded within attachment experiences. Individuals with depression tend to score lower on reflective functioning, the operationalized term for mentalizing, when scored/assessed through the Adult Attachment Interview. This alludes to the likely connection between depression and impaired mentalization. In the face of stress and/or adversity, depressive symptoms become triggered within already vulnerable individuals with impaired mentalizing capacities. These depressive symptoms result in a reemergence of non-mentalizing modes of thinking that lead to distorted perceptions of self, others, and the world. However, one important understanding within MBT is that it is not the prevalence of adverse experiences that is the cause of vulnerability to depressive disorders, but rather the impact that these experiences have on mentalizing. In other words, depressive symptoms are considered the consequence rather than the cause of depressive states; which in turn are the consequence of impairments in mentalizing. An important caveat is the consideration that depressive states are also a human reality during times of intense crisis, and may temporarily overwhelm any individual's mentalizing capacities (Bateman et al., 2012).

Taking an attachment perspective for depressive disorders, MBT identifies attachment and interpersonal issues to be at the root of the developmental origins of depression, including the intergenerational transmission of depression. Insecure attachments relate to an individual's vulnerability to depression, and have been shown to be related to recurrent depression, greater number of depressive episodes, residual symptoms, longer use of antidepressants, and impaired social functioning. Attachment experiences also play an important role in a child's developing stress system, and insecure attachments have been shown to impair affect regulation, stress responsivity, and social problem solving skills. In other words, there are intimate ties between attachment experiences, stress, and mentalization in depressive disorders. MBT also understands depressive symptoms to reflect a response to perceived threats to attachment relationships, and thus a threat to the self, either because of impending separation, rejection, or loss, and/or impending failure experiences. Because of the central role interpersonal distress plays as a predisposing, precipitating, and at times perpetuating factor in depression, the relational emphasis of MBT is invaluable. Additionally, mentalization is believed to underlie characteristics associated with resilience, such as autonomy, as seen through improved sense of self-worth, feelings of self-efficacy, and relatedness as seen through interpersonal awareness, empathy, and improved ability to draw benefit from social supports (Bateman et. al, 2012).

Depressed moods often reflect a psychic equivalence quality of thinking that has a felt sense of permanence and leaves little room for symbolization or inner security for mental exploration. The psychic equivalence mode of thinking within depressive states also disrupt an individual's experience of time; leaving the past, present, and future to feel undifferentiated and equally painful and immovable. This psychic equivalence can readily lead to a felt sense of hopelessness, helplessness, and reduced drive. Suicidal thoughts/actions within MBT are

conceptualized as the psychic equivalence thinking of painful inner states as feeling overwhelmingly pervasive, and leading to a teleological solution of self harm in an attempt to silence painful internal states. Ultimately, within depressive disorders, mentalizing moves to the polarities of automatic and affective focused, resulting in the failure to reappraise and shift negative affect (Bateman et. al, 2012).

Client's struggling with depressive disorders may also shift into a teleological stance of equating desires/feelings with observable behavior or material causes. Clinical populations with depression may view internal experiences only through physical expressions, such as love only evidenced by the other being present, buying gifts, physically touching, etc. This teleological stance may lead to frantic efforts to induce counselor attachment figures to demonstrate that they care, through extending office hours, physical contact, phone calls, etc. Within a teleological stance, clients may have a tendency to seek objective proof of their depression, rigidly seeking biological or environmental causes as explanations while avoiding genuine mentalizing about one's own role in shaping one's life. Additionally, negative automatic thoughts often stem from this teleological stance and then become fueled through psychic equivalence where excessive importance is given to these negative thoughts regarding self, others, and future (Bateman et. al, 2012).

Within the pretend mode, clients with depressive disorders may fall into a state of hypermentalizing that may be difficult to distinguish from genuine mentalizing. This hypermentalizing pretend mode may be identified when the client begins ruminating, becoming overly analytical, repetitive, and expressing lengthy narratives that are predominately cognitive and out of touch with any underlying affect. Importantly, rumination has been shown to decrease moods, whereas mentalizing has been shown to improve moods. Pretend modes may also be

distinguished from genuine mentalizing, when the client has difficulty switching perspectives and shifting from self to other- focus, or vis versa (Bateman et. al, 2012).

MBT for depressive disorders understands attachment strategies, such as rumination and/or self-criticism to serve interpersonal functions of seeking help and attempting to regulate internal mental states within the attachment system. Interventions aimed at fostering mentalizing are primarily attempts to enhance attachment strategies through co-regulating arousal and stress in the context of a secure counseling relationship. MBT begins by exploring interpersonal relationships and possible distortions that underpin recurring interpersonal problems, rooted within maladaptive interpersonal understandings of mental states in relation to self and other. MBT with depressive disorders is primarily focused on dominant interpersonal narratives and maladaptive feedback loops created through dysfunctional transactional cycles/attachment strategies. Through the exploration and identification of these narratives and cycles/strategies, MBT attempts to link interpersonal themes to present symptoms/mental states, and work through the client's transference reactions; i.e. mentalizing the transference. At the core of this approach is the unwavering focus on the client's mind in the context of the secure counseling attachment relationship. The counselor seeks to foster mentalizing through genuine investment in thinking with the client about mental states and how they influence symptoms, as well as attachments (Bateman et. al, 2012).

To achieve these goals discussed above, MBT for depressive disorders follows a three-phase treatment trajectory. In the first phase, MBT counselors seek to engage the client in treatment through active, supportive, empathic interventions promoting hope and structure. MBT counselors implement various techniques to recover mentalizing, such as providing a holding/containment environment, psychoeducation, behavioral activation, etc. Before moving

on to phase two, MBT attempts to identify and explore the client's typical maladaptive

interpersonal cycles/narratives, understanding typical attachment strategies used to cope with

interpersonal stress and linking these to symptomology. During the second phase, the MBT

counselor collaborates with the client in working through these identified interpersonal

issues/conflicts through fostering mentalization regarding self and other, particularly using the

here and now of the therapeutic relationship. This is accomplished through mentalizing the

transference, in the hopes of extending the client's awareness of interpersonal patterns and how

their behaviors are fueled by mental states. MBT counselors are also actively attempting to foster

resilience in the face of past, present, and future adversity through encouraging clients to

mentalize and attempt new ways of dealing with adversity, particularly in relating to self and

other. Lastly, in the third phase, the MBT counselor works with the client in dealing with any

issues of loss, separation, autonomy, and identity that may be triggered by the ending of

treatment. Ultimately, the counseling process is reviewed, achievements are explored, and any

changes or new understandings are consolidated in the hopes of preventing future depressive

episodes (Bateman et. al, 2012).

Mentalization Based Treatment for Trauma-Related Disorders

As discussed earlier within attachment theory, trauma in MBT is conceptualized through

a developmental psychopathology perspective attempting to take into account complex

developmental attachment trajectories. Childhood traumatic attachments compromise the

development of mentalization, and may influence neurobiological development in ways that

shape basic emotional regulation and adaptive strategies. Children growing up within traumatic

attachments adapt with survivalist insecure attachment patterns, leaving little room for safe

emotional/social learning; i.e. mentalizing. Additionally, crisis throughout any period of life

presents challenges for anyone, but particularly vulnerable are those individuals whose interpersonal capacities are weakest; i.e. those with maladaptive attachment strategies/insecure attachment patterns. Having a history of secure attachments provides a protective layer for responding to crisis in relatively adaptive ways (Bateman et. al, 2012).

Clients with trauma-related disorders often enact non-mentalizing modes of thinking. Post-traumatic flashbacks can be viewed through the psychic equivalence mode as all too real, and often then combated with the dissociative qualities of the pretend mode. Oscillating between the pretend mode and psychic equivalence is proposed to be a hallmark of traumatization. A teleological stance may serve to produce concrete actions, such as substance abuse, self-injury, binging/purging, in the hopes of protecting against these overwhelming flashbacks and emotions. Client's with trauma histories in a teleological stance may give little weight to verbal reassurances, and understand actions as the only way to alter thoughts and feelings. Relating to a traumatic event, clients may think the mind of someone else is only altered through actions in the same way the client's mind was altered through traumatic actions; i.e. teleologically altering another's mind through threat or seduction. Additionally, overwhelming fearful states of mind are often pervasive following trauma, such as hypervigilance. Clients may discover that mentalizing can provide a "pause button" to serve as a sort of buffer between feelings and actions (Bateman et. al, 2012).

MBT for trauma-related disorders seeks to promote mentalizing painful emotions and conflicts in the context of an attachment relationship. First and foremost, MBT prioritizes a safe, reliable, and containing therapeutic environment. MBT counselors strive to establish interpersonal security within the therapeutic relationship, creating the best possible conditions for clients to be able to approach in their minds what may feel entirely overwhelming, disturbing,

and/or terrifying. MBT aims to provide opportunities for clients to reconstruct their narratives and find or make meaning through the process. Within the mentalizing stance, counselors facilitate an opportunity for the client to rediscover that he/she has a mind, and find their authentic psychological self through the mind of a benign, secure attachment figure engaged in a reciprocal mentalizing relationship. At the core of this process must be trust and hope that the counselor will truly listen to the client and hold their narrative so that the effect of the experience, no matter how bleak, can slowly become more integrated. Counselors must demonstrate the capacity to contain painful emotions and remain collaboratively engaged in a mentalizing stance. In holding difficult emotions within a mentalizing stance, the MBT counselor models a new way of approaching the contents of one's mind openly, and in turn deepening one's perspective on particular experiences. In other words, the counselor must sustain a mentalizing stance while thinking the unthinkable with the client (Bateman et. al, 2012).

The central task in MBT for trauma-related disorders is to support this mentalizing stance towards the meaning and effects of the trauma, holding a primary focus on the client's mind, not the event. Negative thoughts about the self, safety within the world, and any perceived responsibility for the trauma are shown to perpetuate post-traumatic stress disorder. As a result, these thoughts/feelings are particularly important to address, empathically work through, and mentalize. MBT aims to elaborate a client's conscious and unconscious meaning of the trauma. In doing so, the goal is to collaboratively develop an affectively grounded narrative about the effects/meaning of the traumatic event, and allow for flexible and different perspectives on the experience. Narrative coherence has been shown to be a mechanism of change, and MBT seeks to bridge the pre- and post-trauma self with a coherent narrative that is looking towards the future. Ultimately, MBT's goal is to promote client curiosity about their own minds and focus on

current mental states. Counselors strive to help clients make sense and explore the effects the trauma has had on their current functioning and relationships, and develop some perspective on the past by reworking and mentalizing current experiences (Bateman et. al, 2012).

Conclusion

The construct of mentalization has profound influences on the counseling process, and holds far reaching implications for both clients and counselors alike. Understanding how mentalizing capacities develop, and how mentalization is enhanced or prohibited, provide an essential framework for counselors to develop a nuanced conceptualization of clients and the counseling process. The professional field of counseling continues to grow and progress in dynamic ways, and ongoing research around mentalization will no doubt produce greater insights into the complex interactions between mentalizing capacities and overall mental health.

Mentalization ultimately provides an underlying counseling model in which to view client's presenting concerns, counselor's implicit and explicit contributions to therapy, and the interpersonal process within the therapeutic relationship. Mentalizing serves to promote a reflective process that increases awareness, expands humility, and strengthens an empathic and inquisitive stance towards exploration and understanding. Mentalization strives to eliminate assumptions, illuminate miscommunications, and wholeheartedly embrace an individual's humanity. Mentalizing allows for relationships to be the necessary secure base and safe haven needed for growth. Mentalization is a spirit, or way of being, as a counselor and holds a dynamic, empathic, and I-thou essence that allows for the possibility of change to occur through a secure, healing relationship.

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Appendices

The 17 items of the MBT adherence and competence scale and the "good enough" quality level

(Katerud et al., 2012, p.13).

Item Name	Good enough quality level (4)
1. Engagement, interest, and warmth	1. The therapist appears genuinely warm and interested. The rater gets the impression that the therapist cares. Several concrete comments communicate this positive attitude.
2. Exploration, curiosity, and a not-knowing stance	2. The therapist poses appropriate questions designed to promote exploration of the patient's and others mental states, motives and affects and communicate a genuine interest in finding out more about them.
3. Challenge unwarranted beliefs	3. The therapist confronts and challenges unwarranted opinions about oneself or others in an appropriate manner.
4. Adaptation to mentalizing capacity	4. The therapist seems to have adapted to the patient's mentalizing level and the intervention are for the most part short, concise and unpretentious.
5. Regulation of arousal	5. The therapist plays an active role in terms of maintaining emotional arousal at an optimal level (not too high so that the patient loses his or her ability to mentalize; not too low so that the session becomes meaningless emotionally).
6. Stimulating mentalization through the process	6. The aim of the interventions clearly seems to be to stimulate the mentalizing of experiences of self and others in an ongoing process and is less concerned about content and interpretation of content in order to promote insight.
7. Acknowledging positive mentalizing	7. The therapist identifies and explores good mentalization and this is accompanied by approving words or judicious praise.
8. Pretend mode	8. The therapist identifies pretend mode and intervenes to improve mentalizing capacity.
9. Psychic equivalence	9. The therapist identifies psychic equivalence functioning and intervenes to improve mentalizing capacity.
10. Affect focus	10. The inventions focus primarily on affects, more than on behavior. The attention is directed at affects as they are

	expressed in the here and now, and particularly in terms of the relationship between patient and therapist.
11. Affect and interpersonal events	11. The therapist connects emotions and feelings to recent or immediate interpersonal events.
12. Stop and rewind	12. The therapist identifies at least one incident in which the patient reacts in a maladaptive way to an interpersonal event, then tries to slow down the pace and find out about the incident step-by-step.
13. Validation of emotional reactions	13. The therapist expresses a normative view on the warranted nature of the patient's emotional reaction(s) after these are sufficiently investigated and understood.
14. Transference and the relation to the therapist	14. The therapist comments on and attempts to explore – together with the patient – how the patient relates to the therapist during the session and stimulates reflections on alternative perspectives whenever appropriate.
15. Use of countertransference	15. The therapist actively utilizes his/her own feelings and thoughts about the relationship to the patient and attempts by this to stimulate an exploration of the relationship between them.
16. Monitoring own understanding and correcting misunderstanding	16. The therapist checks out his/her understanding of the patient's state of mind and to what extent this corresponds with the patient's understanding and openly admits to any misunderstanding whenever they occur.
17. Integrating experiences from concurrent group therapy	17. The therapist stimulates exploration of the patient's experiences from the group therapy sessions and helps to integrate the material so that the treatment as a whole is coherent.

Self-Rating of MBT Adherence

"The extent of adherence is scored by adding up the number of "yes" answers multiplied by the item weights and dividing by 64; we consider 80% adherence to be the standard."

(Allen, Fonagy, & Bateman, 2008, p. 200-203)

Framework of treatment

Yes   No   DK   My treatment is offered in a clearly structured context that is transparent to patients and treaters (2)

Yes   No   DK   I have a clear hierarchy of therapeutic goals agreed with patient (2)

Yes   No   DK   I have a crisis plan identified (2)

Yes   No   DK   A case discussion has been organized where roles of other staff have been identified and the limits of confidentiality agreed (1)

Yes   No   DK   My patient appears to understand the rationale of treatment and the purpose of group and individual therapy (1)

Yes   No   I have explained the boundaries of therapy (2)

Yes   No   I have arranged supervision in either peer group or with a senior practitioner (1)

Yes   No   I have reviewed the patient's current relationships and social support network (2)

Yes   No   I have reviewed medication or arranged for review with a colleague. The limits of medication prescribing have been defined (1)

Yes   No   Assessment of mentalization has been completed (1)

Yes   No   Diagnosis has been discussed with the patient (1)

Yes   No   My formulation has been completed and has been discussed with the patient and modified accordingly (2)

Max = 18

Mentalization

Yes   No   I am taking a genuine stance of "not knowing" and attempting to "find out" (2)

Yes   No   I ask questions to promote exploration (1)

Yes   No   In the session I ask about patients' understanding of motives of others (1)

Yes   No   I use transference tracers in this session (1)

Yes   No   I use transference interpretation to highlight alternative perspectives and not to give
                     insights (1)

Yes   No   I challenge unwarranted beliefs about me and patients' experiences of self and other (1)

Yes   No   I do not present the patient with complex mental states (2)

Yes   No   I avoid simplified historical accounts of current problems (2)

Yes   No   I avoid confrontation with patient when he is in psychic equivalence mode (2)

Yes   No   I consider if the pretend mode of mentalization is present in the patient (2)

Yes   No   I address reversibility of mental states (1)

Max = 16

<u>Working with current
mental states</u>

Yes   No   I attend to current emotions (2)

Yes   No   I focus on appropriate expression of emotions (1)

Yes   No   I link affect with immediate or recent interpersonal contexts (1)

Yes   No   I relate understanding of current interpersonal context to appropriate recent past
                     experiences (1)

Max = 5

<u>Bridging the gaps</u>

Yes   No   My reflections aim to present the patient's internal state in a modified form (2)

Yes   No   I give examples to the patient of his experience of psychic equivalence (1)

Yes   No   I focus attention of patient on therapist experience without being persistently self-referent
                     (1)

Yes   No   I negotiate ruptures in alliance by clarifying patient and therapist roles in the rupture (1)

Yes   No   I am trying to develop a transitional "as if" playful way of linking internal and external
                     reality in sessions (1)

Yes	No	I judiciously use humor (1)

Max = 7

Affect storms

Yes	No	I maintain a dialogue throughout the emotional outburst (2)
Yes	No	When emotions are aroused I attempt to clarify the feeling and any underlying emotion without interpretation (1)
Yes	No	I only begin to address possible underlying causes of the affect storm within patient's current life as the emotional state subsides (2)
Yes	No	I identify triggers for the storm in patient's construal of their interpersonal experience immediately prior to it (1)
Yes	No	I link affect storm to therapy process only after storm has receded (2)

Max = 8

Use of transference

Yes	No	I build up over time to transference interpretation (2)
Yes	No	I only use transference interpretation when therapeutic alliance is established (1)
Yes	No	I do not use transference as simple repetition of the past (1)
Yes	No	I use transference to demonstrate alternative perspectives between self and other (1)
Yes	No	I avoid interpreting the therapeutic relationship as part of another relationship that the patient currently has or has had in the past (1)
Yes	No	My transference interpretations are brief and to the point (1)
Yes	No	I refrain from use of metaphor when the patient's mentalizing capacity is reduced (2)
Yes	No	I do not focus on apparent conflict (1)

Max = 10

Characteristics of Interventions that Influence Mentalizing

(Allen, Fonagy, & Bateman, 2008, p. 166-167)

Promoting mentalizing	Undermining mentalizing
• Maintaining an inquisitive, curious, "not-knowing" stance • Providing a secure-base experience that facilitates patients' exploration of mental states – their own and yours • Promoting a level of emotional engagement that is neither too hot nor too cold • Engaging in a mirroring process in which your contingently responsive, "marked" emotions represent the patient's mental state back to the patient • Offering interventions that are simple and to the point • Maintaining a balance between engaging patients in exploring mental states of self and others • Engaging patients in viewing interactions and self-experience from multiple perspectives • Acknowledging when you do not know what to say or do and enlisting the patient's help in moving the process forward • Working with transference so as to help patients understand how their mind is working in the room • Validating the patient's experience before offering alternative perspectives • Challenging patients' unsubstantiated assumptions about your attitudes, feelings, or beliefs • Engaging in judicious self-disclosure regarding your interactions with the patient • Letting patients know what you are thinking so as to permit them to correct your distorted mentalizing • Acknowledging your own mentalizing failures and endeavoring to understand mistakes • Acknowledging mistakes and actively exploring your contribution to the patient's adverse reactions	• Striving to be clever, brilliant, and insightful • Offering complicated, lengthy interventions • Engaging in protracted discourse in the pretend mode ("psychobabble" or "bullshitting") • Attributing mental states to the patient based on your theoretical preconceptions • Presenting your ideas about the patient to the patient with a sense of certainty • Focusing excessively on relationship structure and content instead of relationship processes • Attributing the patient's experience of a relationship to a general pattern rather than exploring the experience and its basis in more detail • Using the transference to explore unconscious repetitions of past behavior • Allowing prolonged silences • Encouraging free association and elaboration of fantasies about the therapist • Responding to the patient with intense, "unmarked" emotion