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Mentalizing and MBT: Working with Non-mentalizing Modes

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Some context about mentalizing

- Mentalizing is an everyday even ubiquitous process that is part of ordinary thought processes and social thinking
- There is nothing exceptional or unusual about a person mentalizing
- Mentalizing can be conscious or it can happen ‘in the background’ of our thinking, that is mainly preconscious

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Some More Context: An Example

- You may be thinking about why I haven't started with a definition of 'mentalizing' first. That is you might be thinking about my mind or keeping 'mind in mind.' This is mentalizing (of the other). I might be noticing currently that I am somewhat anxious about presenting. This is me keeping my own mind in mind (self mentalizing).
- And you might only noticing that you are thinking about what might be going on in my mind now that I have mentioned it (controlled mentalizing) earlier mentalizing might have been 'in the background' (automatic mentalizing)

A definition of mentalizing

"Mentalizing may be defined as perceiving and interpreting behaviour as conjoined with intentional mental states."

- It's the way our mind tells us ***what*** we are feeling and thinking, and ***why*** we are behaving as we are.
- It's also how our mind tells us ***what*** someone else is feeling and thinking and ***why*** they are behaving as they are.

- The normal ability to **ascribe intentions and meaning** to both our **own**... and **others'** behaviour and appearance.

- Includes the ability to experience one's *own* behaviour as coherently organized by mental states, and to differentiate oneself psychologically from others.

Bateman, A., & Fonagy, P. (2006) Mentalization-Based Treatment for Borderline Personality Disorder: A practical Guide. Oxford University Press: Oxford.

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What mentalizing isn't

- Mentalizing is not a synonym for 'thinking' or 'thought'
- If are seeking to understand the origins of a geological element we are thinking but not mentalizing
- Mentalizing is a profoundly social process
- But if we start to wonder about why we are so affected by a particular landscape or geological feature we may be mentalizing

Swenson, C., & Choi-Kain, L. (2015). Mentalization and Dialectical Behaviour Therapy, *American Journal or Psychotherapy, 69*, 199-217.

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What is 'good enough' mentalizing?

Good enough mentalizing is tentative, flexible, speculative in relation to both one's own and others' minds

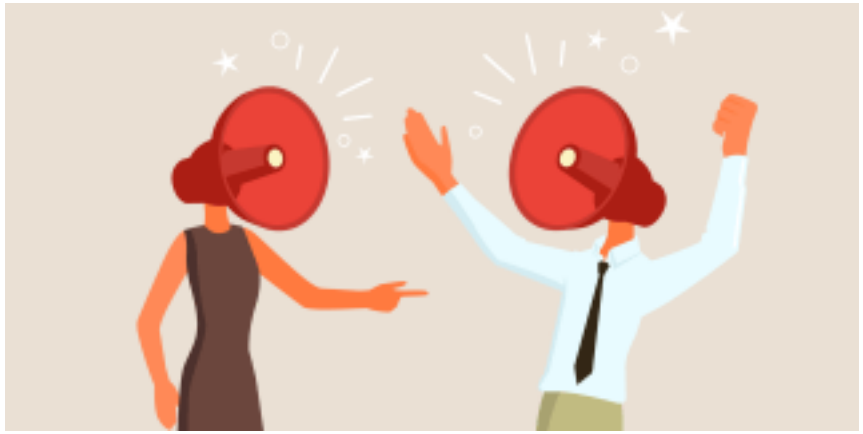
This further involves have the capacity to move between different 'poles' or 'foci'

- Controlled / automatic
- Self / other
- Affective / cognitive
- Internal / external

Mentalizing under Pressure

- Under pressure (high levels of emotional arousal) or when the ‘heat is on’ and particularly in attachment relationships non-mentalizing modes are quite common

- There is a ‘switch point’ when fight / flight / freeze responses come into play and people report ‘not being able to think



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Pre- or non- mentalizing modes

When flexible, tentative or speculative mentalizing is not present, what happens?

For instance, mental experience is ‘the way things are’ and there is no room in my mind for other perspectives or other explanations of what I think is happening?

Psychic Equivalence

(very roughly similar to concrete thinking)

- Reality takes on the quality of being too real.

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Pre- or non- mentalizing modes

When flexible, tentative or speculative mentalizing is not present, what happens?

Or, for instance, what happens when I am so 'caught up in my head' that others or events in my environment don't seem to matter to how I am thinking?

Pretend Mode

(roughly similar to intellectualizing)

- Has the quality of being disconnected from reality (not acutely psychotic)

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Pre- or non- mentalizing modes

When flexible, tentative or speculative mentalizing is not present, what happens?

- Or when only actions have any validity or ‘count as real’?

Teleological Mode (Action mode)

- Actions can start to substitute for mental states in the person’s thinking

Pre-mentalizing modes are common in early childhood and are considered a part of normal development at that age

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Everyday Examples of Non-mentalizing Modes

Psychic Equivalence – "It's just the way it is, you couldn't possibly understand, it just is." "You're angry – I just know you are." "You've got that look."

Pretend mode – Long theoretical explanations of the person's psychological state or particularly emotions that are disconnected from emotion, for instance a long discussion of the 'fractured self' but without any apparent affective content. Can be experienced by others as 'twoodle'.

Teleological mode – "If you loved me you would buy be flowers."

What the MBT therapist does: maintaining mentalizing

Therapist as “a rupture prevention and repair kit.”

Therapist Stance

Maintains a mentalizing or not-knowing stance

Engages in active questioning (without assuming what the answer might be – that would be knowing)

Highlights other perspectives

Encourages reflection through gentle questioning

Is open about own mind including ‘owning up’ to occasional enactments

Focuses on mentalizing process not the content of the narrative

Focuses on affect including how the therapist is perceived by the client

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Responding to pre- / non-mentalizing modes in the work

Psychic Equivalence -

- Bring the level of emotional arousal down by talking about a safer topic and then return to the more emotionally charged topic – don't argue with psychic equivalence

Pretend Mode -

- Start to ask about the how consistent the client's experience is or how it "really was for you"
- Use contrary moves to challenge
- Ask about what was happening in the client's body / the physical sensations in the session

Teleological Mode -

- Ask about what the client needs and then decide if what is being asked for can be understood in terms of those needs

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Using contrary moves

- **Moving the focus from one pole to the other when 'stuck' in one focus**

- Controlled / automatic
- Self / other
- Affective / cognitive
- Internal / external

Important not to be too rigid about this, only use a contrary move when one pole is predominates

A compass not a fixed agenda

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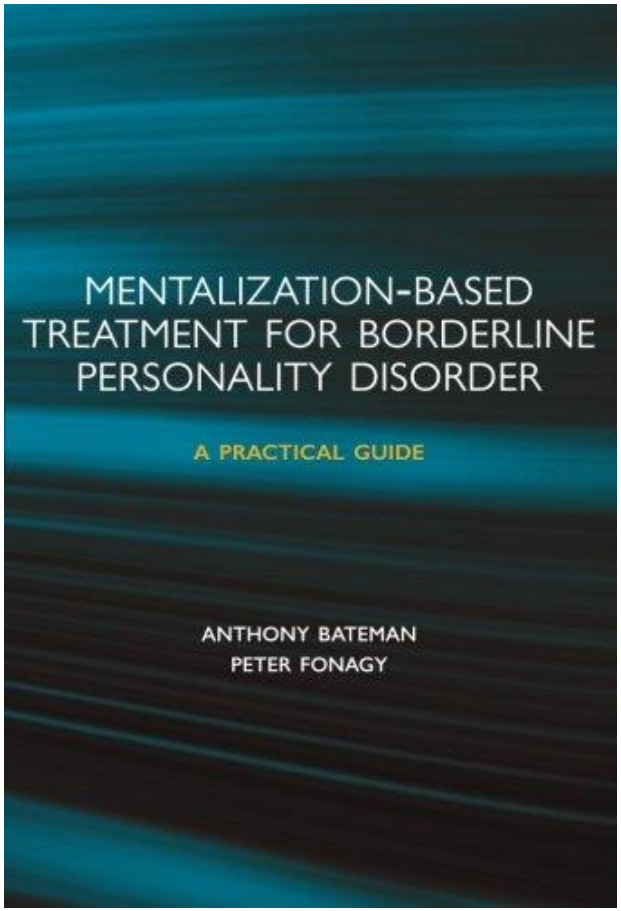
Further resources

- MBT ‘textbook’ and learning / mediational approach



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LITERATURE REVIEW

CLINICAL PSYCHOLOGY SCIENCE AND PRACTICE WILEY

Learning to mentalize: A mediational approach for caregivers and therapists

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Abstract
Mentalization-based therapies (MBTs) are rigorous, theoretically grounded, and evidence-based interventions. However, dissemination of this psychodynamic informed intervention lags behind that of more skills-based therapies due to a lack of concrete operationalization of its key components. In this proof-of-concept article, we describe how the learning (mediational) components of an educational intervention, the mediational intervention for sensitizing caregivers, can operationalize key components of MBTs in behaviorally anchored ways. We suggest that the process of the recovery of mentalizing can be operationalized through five learning components: focusing, affecting, expanding, rewarding, and regulating. In operationalizing the process of rebuilding mentalizing using these observable, behaviorally anchored concepts focusing on creating epistemic trust, we hope to increase the accessibility of MBTs to a wider audience.

KEYWORDS
caregivers, mediational intervention, mentalization-based therapy, mentalizing, psychotherapy

1 | MENTALIZING AND MENTALIZATION-BASED THERAPIES

Mentalizing refers to the capacity to reflect on one's own thoughts and feelings and those of others to predict and understand behavior (Bateman & Fonagy, 2016). The concept has its roots in psychoanalytic literature (Marty & De M'Uzan, 1963) and was incorporated into mainstream neuroscientific and developmental literature in the 1980s and 1990s, and social neuroscience in the 2000s. Several clinical applications of the construct have emerged over the past two decades (see Bateman & Fonagy, 2016 for a review). Mentalizing is a transdiagnostic construct, and the enhancement of mentalizing is suggested to be a general characteristic of any "good" psychotherapy, regardless of the modality, and may be a common factor in positive treatment outcome for all psychotherapies (Fonagy & Allison, 2014).

While different mentalization-based therapies (MBTs) each have unique features, they all share a definition of mentalizing as a form of imaginative mental activity whereby human behavior is implicitly and automatically perceived in terms of putative mental states (e.g., needs, desires, feelings, beliefs, goals, purposes, and reasons) that may account for actions and are sometimes consciously and explicitly reflected upon in mental-state terms (Fonagy, Gergely, Jurist, & Target, 2002). While often categorized as psychodynamic, MBTs are integrative, bringing together aspects of psychodynamic,

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Detecting the Different Modes

TABLE 1. Clues for detecting prementalization states

Description	Example	Relevant features of BPD	Clinician reactions
Psychic equivalence			
Concrete, rigid thought processes paired with unrealistic certainty, making person's position impenetrable to new information and immovable despite inaccuracy *Internal imagination of what happens is equivalent to perception of external reality, without doubt or sense there may be other views or possibilities*	Patient does not receive a return call from a psychiatrist; believing that the psychiatrist is angry with her, she shows up at her next appointment and angrily states, "I know you hate me," leaving the psychiatrist completely perplexed *Action (not returning call) is equated with mental state (anger) and worry about psychiatrist's anger is equated with reality, which prompts angry confrontation with absolute certainty of interpretation of events*	Paranoia, black and white thinking, frantic efforts to avoid abandonment/rejection sensitivity, grandiosity, idealization and devaluation	Confusion, frustration, lack of curiosity paired with defensive increase in therapist's sense of certainty and authority
Pretend mode			
Disconnected, complex, and pseudo-psychological thought processes that have no basis in actual experience or external reality *In contrast to psychic equivalence, there is a complete decoupling of internal and external realities, of what is thought and felt and what is conveyed; referred to as pseudomentalization*	Patient attends treatment dutifully and can talk the talk, appearing to be a "good patient" in sessions, but engages in a secret double life of self-destructiveness and increasing dysfunction *Patient's reality of psychic and behavior dysfunction is walled off and disconnected from what he says to the therapist and does in treatment; this can result in years of intensive, seemingly meaningful therapy without change*	Dissociation, self-harm and suicidality, splitting, secretive or "dishonest" behavior, emptiness, identity diffusion	Boredom; feelings of disconnection or exclusion; feelings of being on autopilot; tendency to try harder or do more work making sense of confused, disconnected material patient brings to session
Teleological mode			
Belief that mental states are only real if they are expressed in actions that are contingent with patient's needs and wishes; different from but overlapping with psychic equivalence in the sense that actions are equated with mental states that match the patient's wishes, giving him or her a sense of being in control of the actions of others	Patient demands proof that a therapist is dedicated by requesting special treatment, such as double sessions and rides home; when therapist refuses, patient self-harms to communicate distress and elicit rescuing by the therapist *Boundary crossings become an index of caring and self-harm an index of pain, which function to control or provoke predictable responses in therapist*	Self-harm, suicidality, "manipulative" behavior, promiscuity, frantic efforts to avoid abandonment	Feeling compelled to act or respond to patient in behavioral ways (boundary crossings, hospitalization and medication when in crisis) to make patient feel cared for or important; frustration; futility in ability to satisfy patient

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