

Mentalising in clinical practice: a workshop

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Aims

- Introduction to mentalising
- Therapist stance
- Assessment of mentalising
 - Clinical
 - Research
- Mentalising and other therapies
 - Clinical practice



Introduction to mentalisation

Concept of Mentalisation

- Freud
 - Thinking arising in response to absence
 - Binding of somatic drive energies into thought (Bindung)
- Lecours and Bouchard (1997)
 - Representation and symbolisation transform drive-affect experiences into mental phenomena
- Bion (1962)
 - Capacity for tolerating frustration enables the psyche to develop thought
- Winnicott (1971)
 - Maternal mirroring in the development of the self
- Bowlby (1973)
 - Attachment and loss
- Premack and Woodruff (1978)
 - ToM as cognitive capacity



Mentalising: A new word for an ancient concept

Implicitly and explicitly interpreting the actions of oneself and other as meaningful on the basis of intentional mental states

(e.g., desires, needs, feelings, beliefs, & reasons)



Introduction to theory of mentalisation

- The normal ability to ascribe intentions and meaning to human behaviour
- Ideas that shape interpersonal behaviour
- Make reference to emotions, feelings, thoughts, intentions, desires
- Shapes our understanding of others and ourselves
- Central to human communication and relationships
- Underpins clinical understanding, the therapeutic relationship and therapeutic change

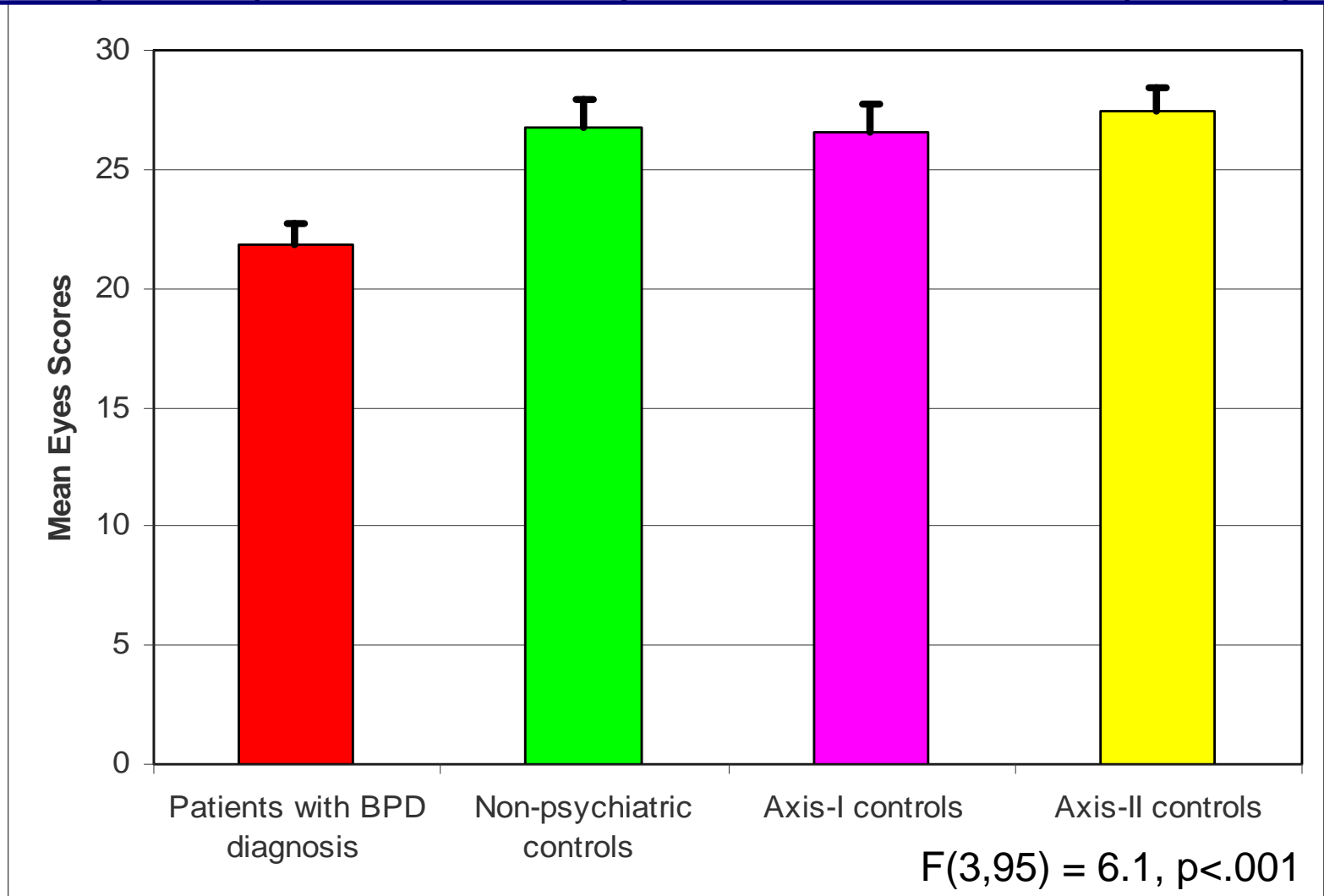
Characteristics of mentalising

- Central concept is that internal states (emotions, thoughts, etc) are opaque
- We make inferences about them
- But inferences are prone to error
- Overarching principal is to take the “inquisitive stance”

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Interpersonal behaviour characterised by an expectation that one's mind may be influenced, surprised, changed and enlightened by learning about another's mind

Mean Eyes Scores of BPD (n=25) Cluster A/B (n=25), Axis-I (n=24) and non-Psychiatric Controls (n=25)

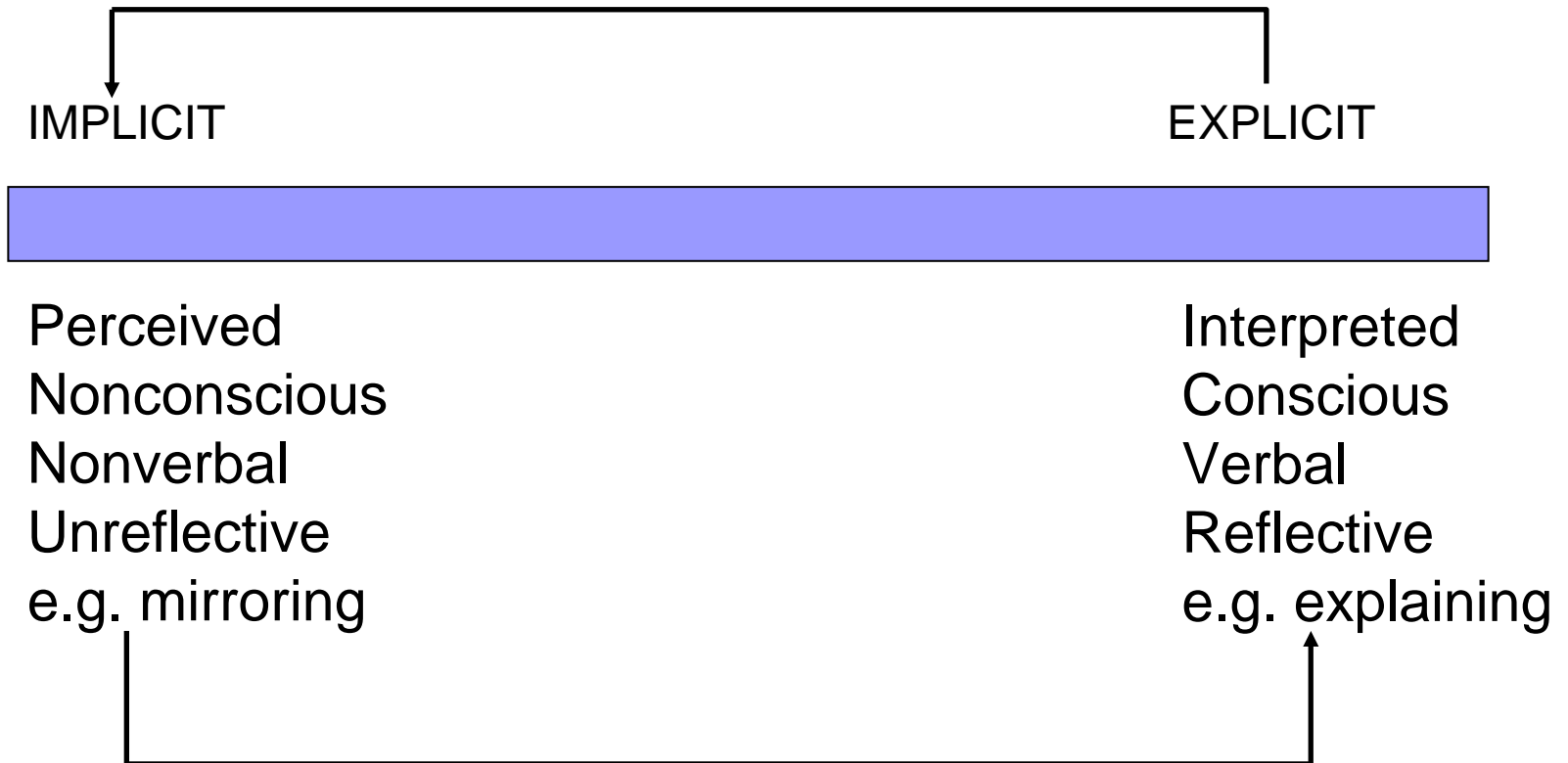


(Fonagy, Stein, Allen & Vrouva, submitted)

Mentalising as an umbrella term

- Full range of mental states
- Implicit (intuitive) and explicit (deliberate) processes
- Self and others dimension
- Cognitive and Affective
- Varying time frame
 - Present
 - past (hindsight)
 - future (anticipatory)
- Varying scope
 - narrow (e.g., feeling at the moment)
 - broad (e.g., autobiographical narrative)

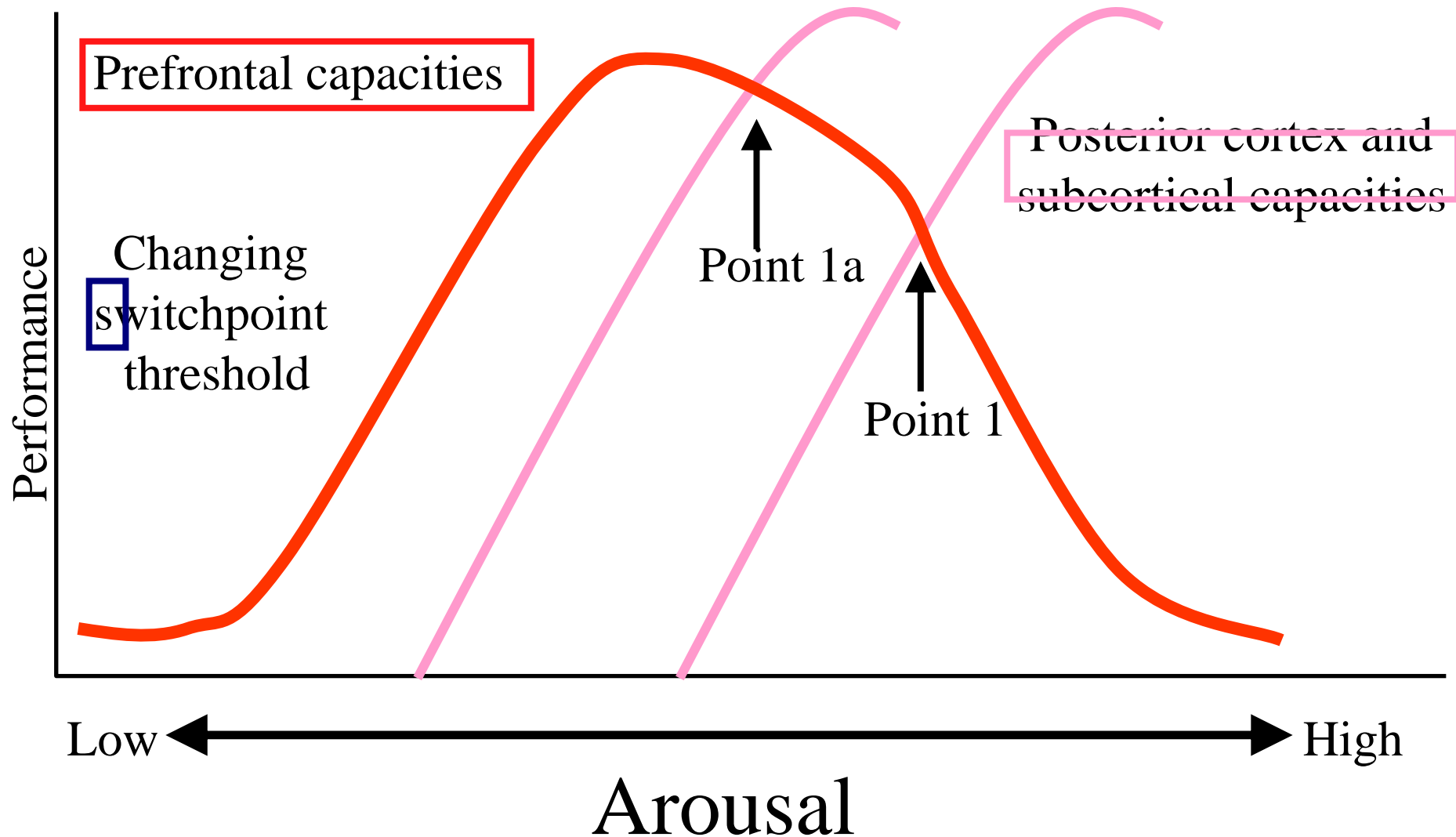
Mentalizing: Implicit 'v' Explicit



Being misunderstood

- Although skill in reading minds is important, recognising the limits of one's skill is essential
- First, acting on false assumptions causes confusion
- Second, being misunderstood is highly aversive
- Being misunderstood generates powerful emotions that result in coercion, withdrawal, hostility, over protectiveness, rejection

Mayer's (2001) Adaptation of Arnsten's Dual Arousal Systems Model: Implication of the Hyper-activation of Attachment

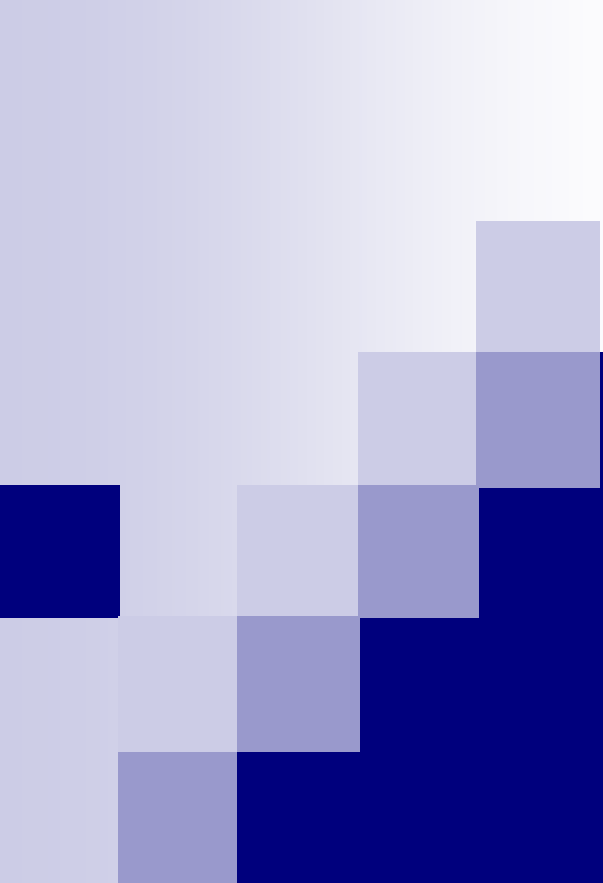


Mentalisation and conceptual cousins

Component	Mindfulness	Psychological Mindedness	Empathy	Affect consciousness
Implicit	No	No	Yes	No
Explicit	yes	Yes	Yes	Yes
Self-orientated	Yes	Yes	Minimal	Yes
Other orientated	No	Minimal	Yes	Yes
Cognitive/ Affect	Cog=Affect	Cog=Affect	Affect>Cog	Affect>Cog

Mindfulness

- Keeping one's consciousness alive to the present reality
- Observing and describing one's own experience whilst participating non-judgementally
- Two domains
 - Attention regulation
 - Acceptance and openness to experience
- Four Skills
 - Observing
 - Describing
 - Acting with awareness
 - Accepting without judgement



Some common criticisms of the concept of mentalization

Old wine in new bottles?

- A particularly ugly term to describe Bion's and Winnicott's concepts.
- Explicitly acknowledged:
 - “mentalization was the least original concept” in the dictionary of psychological thought.
 - “mentalizing-focused treatment is the least novel therapeutic approach imaginable, simply because it revolves around a fundamental human capacity—indeed, the capacity that makes us human” (Allen & Fonagy, 2006, p.24).

Where is the unconscious?

- mentalization has no right to a psychoanalytic identity because it is not framed in the context of the dynamic unconscious
 - refers to a fundamental mental process outside conscious awareness, but this does not obviate the charge of superficiality
- Mentalization is a dynamic concept
 - it is sometimes violently resisted – a world populated with unthinking concrete objects functioning in the psychic equivalent mode can be frequently unconsciously preferred
 - what we do in mentalizing-focused treatment—including using the word, “mentalizing”—aims merely to draw attention to mentalizing.

Does mentalization theory privilege environmental deficit over conflict?

- Conflicts can cause an apparent deficit in mentalization
 - An adult contemplating genuinely malevolent thoughts and feelings about a child → the child may withdraw into a state where non-mentalization is to be preferred
 - the malevolent thoughts of the adult may not be real but are imagined by the child → phantasy may be the product of neurotic compromise, as in the oedipal child imagining paternal retribution

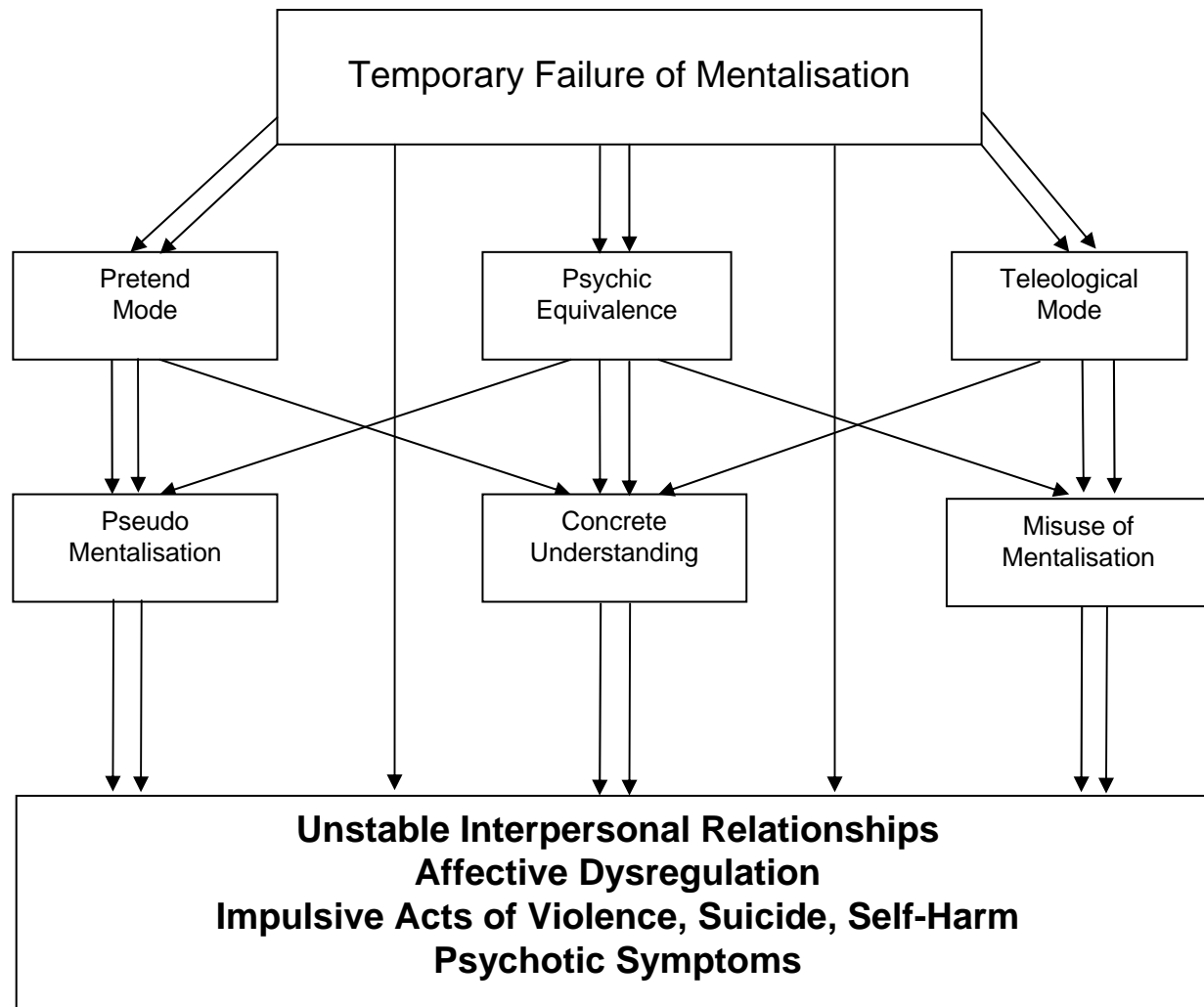
Does mentalization theory of BPD privilege environmental deficit over conflict?

- Hanna Segal: In all of us thinking overrides the sense of omnipotence we derive from phantasy and it should not surprise us that it (thinking) is so commonly fiercely resisted
- Underpinning apparent deficits is the mind's ability to switch off cognitive functions (mental processes) that generate painful contents (mental representations).
 - Therapy has to work to reactivate decoupled mental processes through a process Anna Freud eloquently described as “developmental help”.
 - Dealing with conflict via inhibition occurs more often when a capacity is not well established in the first place



Assessment of Mentalization

Understanding suicide and self-harm in terms of the temporary loss of mentalisation



Questions that can reveal quality of mentalisation

- *why did your parents behave as they did during your childhood?*
- *do you think your childhood experiences have an influence on who you are today?*
- *any setbacks?*
- *did you ever feel rejected as a child?*
- *in relation to losses, abuse or other trauma, how did you feel at the time and how have your feelings changed over time?*
- *have there been changes in your relationship with your parents since childhood?*

Elaboration of interpersonal event

- Thoughts and feelings in relation to the event
- Ideas about the other person's mental state at turning points in narrative
 - Elaborate on actual experience
 - Reflecting on reconstructed past
- Understanding own actions (actual past and reflection on past)
- Counter-factual follow-up questions

Interpersonal interaction

- Last night Rachel and I had an argument about whether I was doing enough around the house. She thought I didn't do as much as her and I should do more. I said I did as much as my work obligations allow. Rachel got angry and we stopped talking to each other. In the end I agreed to do the shopping from now on. But I ended up feeling furious with her



What does non-mentalizing look like?

- Excessive detail to the exclusion of motivations, feelings or thoughts
- Focus on external social factors, such as the school, the council, the neighbours
- Focus on physical or structural labels (tired, lazy, clever, self-destructive, depressed, short-fuse)



What does non-mentalizing look like?

- Preoccupation with rules, responsibilities, 'shoulds' and 'should nots'
- Denial of involvement in problem
- Blaming or fault-finding
- Expressions of certainty about thoughts or feelings of others

What does good mentalizing look like?

- In relation to other peoples thoughts and feelings
 - Acknowledgement of opaqueness
 - Absence of paranoia
 - Contemplation and reflection
 - Perspective taking
 - Genuine interest
 - Openness to discovery
 - Forgiveness
 - predictability

What does good mentalizing look like?

- Perception of own mental functioning
 - Appreciation of changeability
 - Developmental perspective
 - Realistic scepticism
 - Acknowledgement of pre-conscious function
 - Awareness of impact of affect
- Self-presentation e.g. autobiographical continuity
- General values and attitudes e.g. tentativeness and moderation

What does extremely poor mentalizing look like?

■ Anti-reflective

- hostility
- active evasion
- non-verbal reactions

■ Failure of adequate elaboration

- Complete lack of integration
- Complete lack of explanation

■ Inappropriate

- Complete non-sequiturs
- Gross assumptions about the interviewer
- Literal meaning of words

Assessment of mentalization

- Distinguish four main types of problem - not mutually exclusive; more than one may apply to the same person
 - Concrete understanding
 - Generalised lack of mentalising
 - Context-specific non-mentalising
 - Non-mentalising is variable and occurs in particular contexts
 - Pseudo-mentalising
 - Looks like mentalising but missing essential features
 - Misuse of mentalising
 - Others' minds understood and thought about, but used to hurt, manipulate, control or undermine



Mentalising and therapy



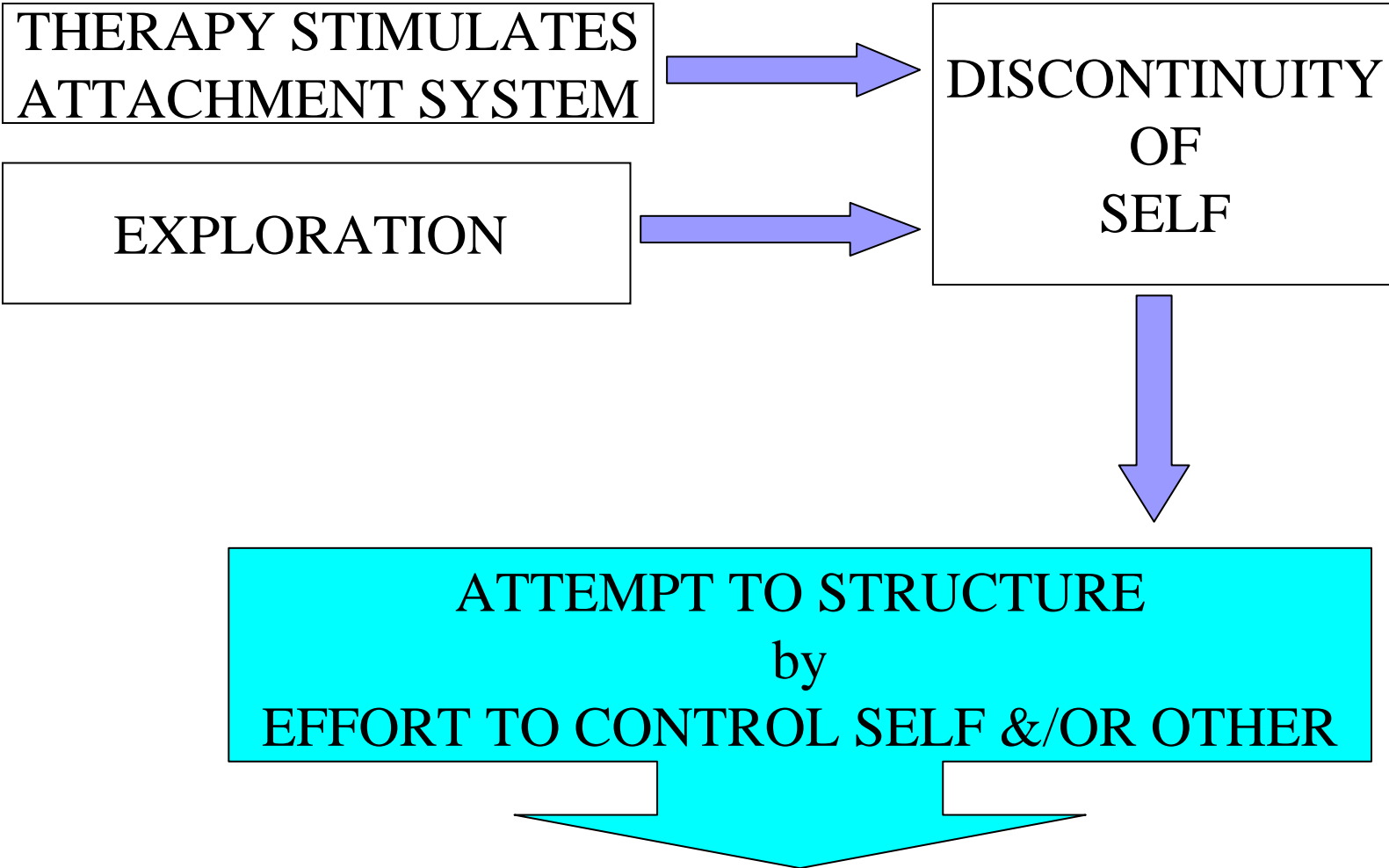
Therapist stance

The Artful use of Science

- To do anything well you must have the humility to bumble around a bit, to follow your nose, to get lost, to goof. Have the courage to try an undertaking and possibly do it poorly. Unremarkable lives are marked by the fear of not looking capable when trying something new.

Epictetus, *Manual*

Therapist/Patient Problem



Therapist/Patient Problem

ATTEMPT TO STRUCTURE
by
EFFORT TO CONTROL SELF &/OR OTHER



RIGID SCHEMATIC REPRESENTATION
NON-MENTALIZING
CONCRETE MENTALIZING (PSYCHIC EQUIVALENCE)
PSEUDO MENTALIZING (PRETEND)
MISUSE OF MENTALIZING

Therapist Stance

■ Not-Knowing

- Neither therapist nor patient experiences interactions other than impressionistically
- Identify difference – ‘I can see how you get to that but when I think about it it occurs to me that he may have been pre-occupied with something rather than ignoring you’.
- Acceptance of different perspectives
- Active questioning
- Eschew your need to understand – do not feel under obligation to understand the non-understandable.

■ Monitor your own mistakes

- Model honesty and courage via acknowledgement of your own mistakes
 - Current
 - Future
- Suggest that mistakes offer opportunities to re-visit to learn more about contexts, experiences, and feelings

Therapist stance

- Empathic is about how they are thinking and feeling, getting them to describe this is important
- Cannot explore feeling before establishing empathy
- Use not knowing what to say as clue that something does not make sense and there is something to be curious about
- Curiosity about experience, probing about patients experience serves to validate the experience
- Normalizing is component of moving to transference work – stating feelings in first person: “I would feel X, so surprised you appear not to...”

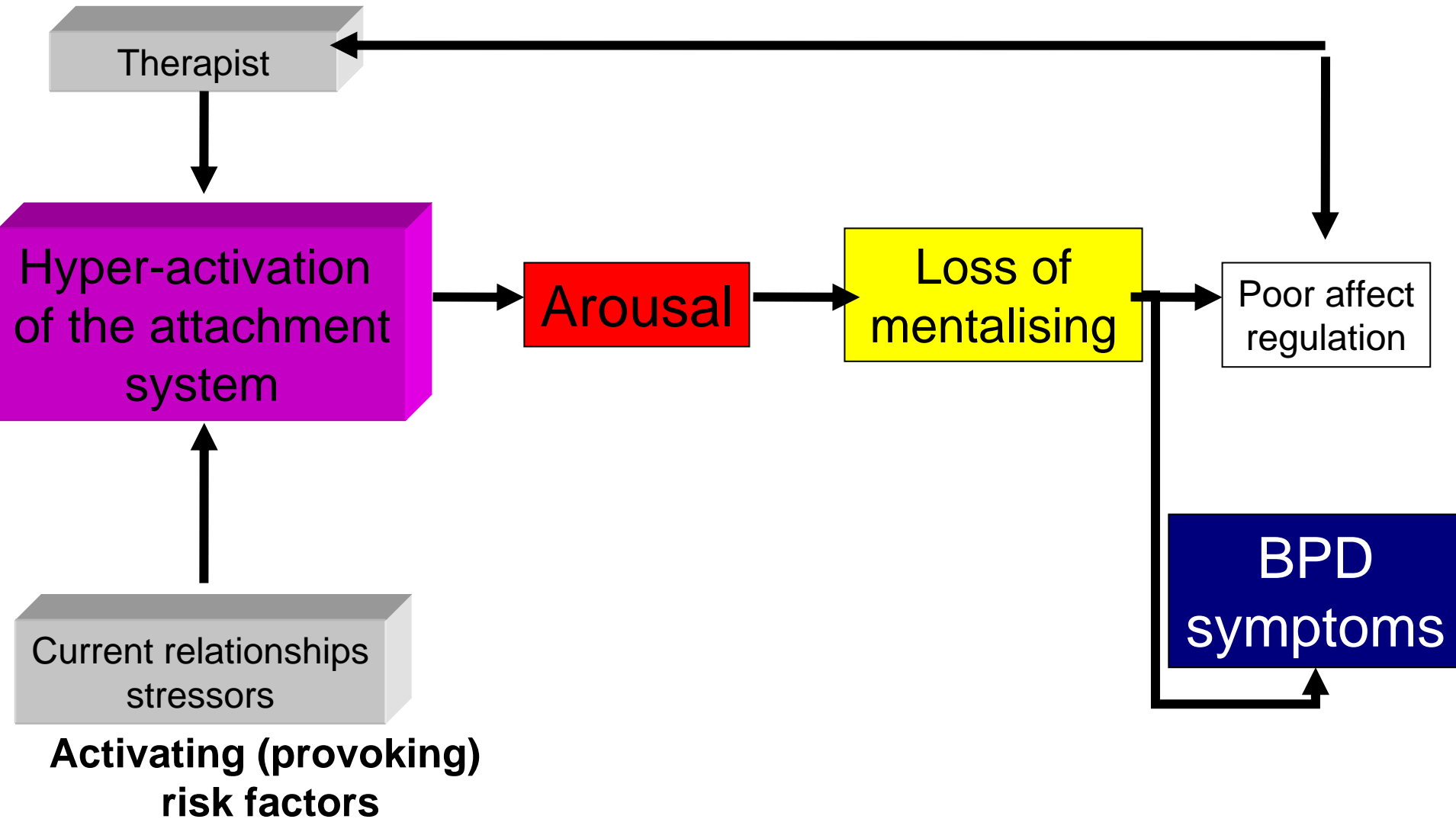
Essential to the Stance

- Keep it current – what the patient feels right now
- Start by empathising – finding a way of stating that you genuinely understand distress
- Explore in the relational realm not just the intrapsychic
- Lower arousal by bringing it to the person of the therapist
 - What have I done?
- Stick to mentalizing aim in somewhat dogged manner
- Quickly step back if patient seems to lose control

Being misunderstood

- Although skill in reading minds is important, recognising the limits of one's skill is essential
- First, acting on false assumptions causes confusion
- Second, being misunderstood is highly aversive
- Being misunderstood generates powerful emotions that result in coercion, withdrawal, hostility, over protectiveness, rejection

Schematic Model of Latrogenesis





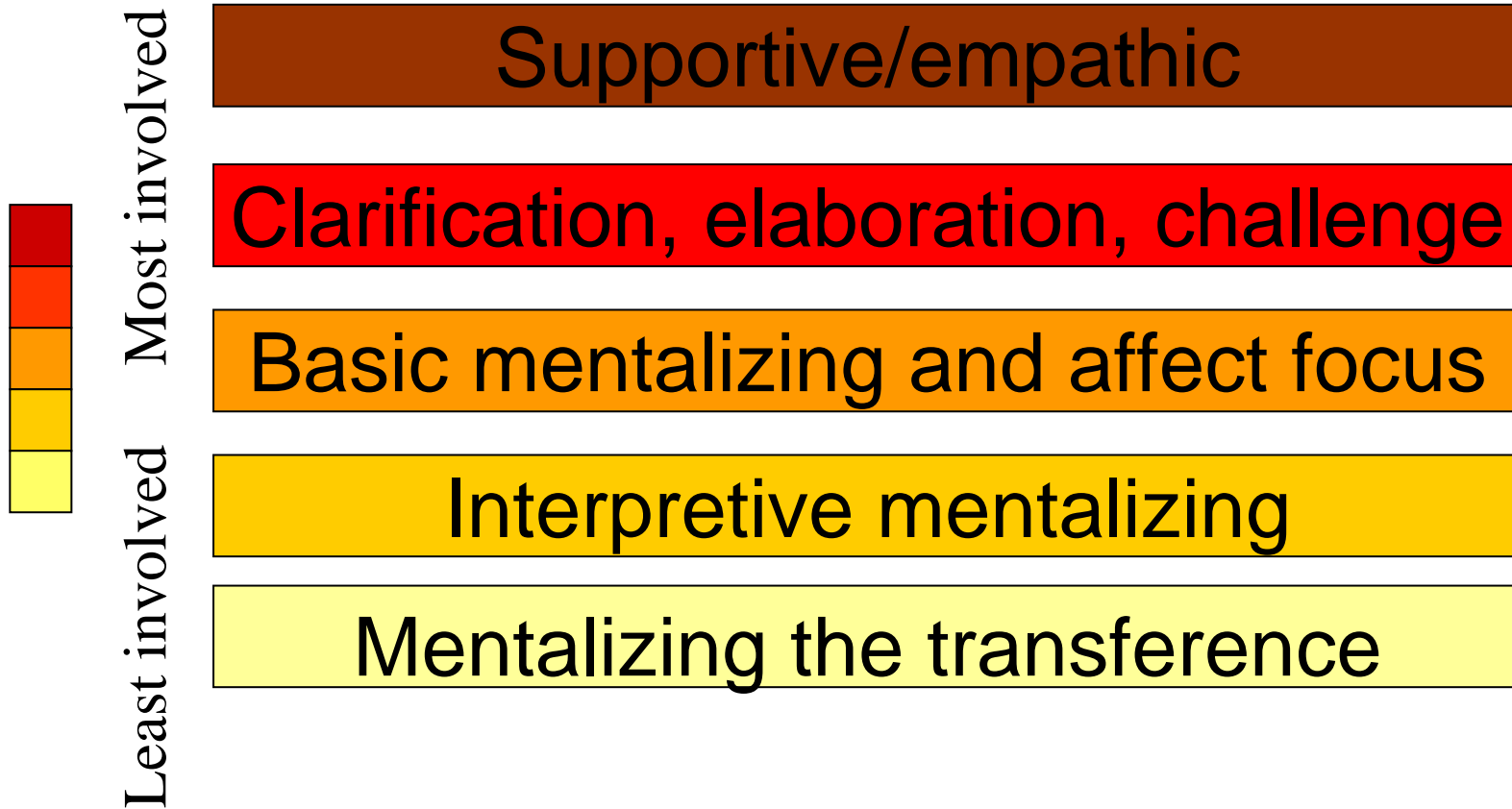
The mentalizing focus



Interventions: principles

- Simple
- Affect focused but remember most reactions are about survival
- Focus on patients mind (not on behaviour)
- Relate to current event or activity – mental reality (evidence based or in working memory)
- De-emphasise unconscious concerns in favour of near-conscious or conscious content

Interventions: Spectrum





Interventions:

Supportive & empathic

- Respectful of their narrative and expression
- Positive/hopeful but questioning
- Unknowing stance – you cannot know their position
- Demonstrate a desire to know and to understand
- Constantly check-back your understanding – ‘as I have understood what you have been saying is...
- Spell out emotional impact of narrative based on common sense psychology and personal experience
- For the patient but not acting for them – retains patient responsibility



Intervention:

Clarification & Affect elaboration

- Clarification is the ‘tidying up’ of behaviour which has resulted from a failure of mentalization
- Establish important ‘facts’ from patient perspective
- Re-construct the events
- Make behaviour explicit– extensive detail of actions
- Avoid mentalizing the behaviours at this point
- Trace action to feeling
- Seek indicators of lack of reading of minds

Intervention: Confrontation and Challenge

■ Stop and Stand

- Persist and decline to be deflected from exploration - 'Bear with me, I think we need to continue trying to understand what is going on'
- Steady resolve - 'I can understand that you want me to support what you are doing but I don't think that would be right because...'
- Convert deceit into frank truth - 'although you feel he has so much that he wouldn't miss it, the fact is that having stolen it you are a thief'
- Identify affect attached to action – 'I can see that although you tried not to 'con' them, the pleasure and delight of doing it seems to have been stronger'
- Ensure 'here and now' aspects are included in the challenge

Interventions:

Basic Mentalizing

■ **Stop, Re-wind, Explore**

- Lets go back and see what happened just then. At first you seemed to understand what was going on but then...
- Lets try to trace exactly how that came about
- Hang-on, before we move off lets just re-wind and see if we can understand something in all this.

■ **Labeling with qualification** (“I wonder if...” statements)

- Explore manifest feeling but identify consequential experience – ‘Although you are obviously dismissive of them I wonder if that leaves you feeling a bit left out?’
- ‘I wonder if there are some resentments that make it hard for you to allow yourself to listen to rules. Lets think about why the rules are there?’
- ‘I wonder if you are not sure if it’s OK to show your feelings to other people?’



The implication of the temporary loss of mentalising

1. Psychic Equivalence
2. Pretend Mode
3. Teleological Stance

The Modes of Psychic Reality That Antedate Mentalisation and Characterize Suicide/Self-harm

■ Psychic equivalence:

- Mind-world isomorphism; mental reality = outer reality; internal has power of external
- Experience of mind can be terrifying (flashbacks)
- Intolerance of alternative perspectives (“I know what the solution is and no one can tell me otherwise ”)
- Self-related negative cognitions are TOO REAL! (feeling of badness felt with unbearable intensity)

The Modes of Psychic Reality That Antedate Mentalisation and Characterize Suicide/Self-harm

■ Pretend mode:

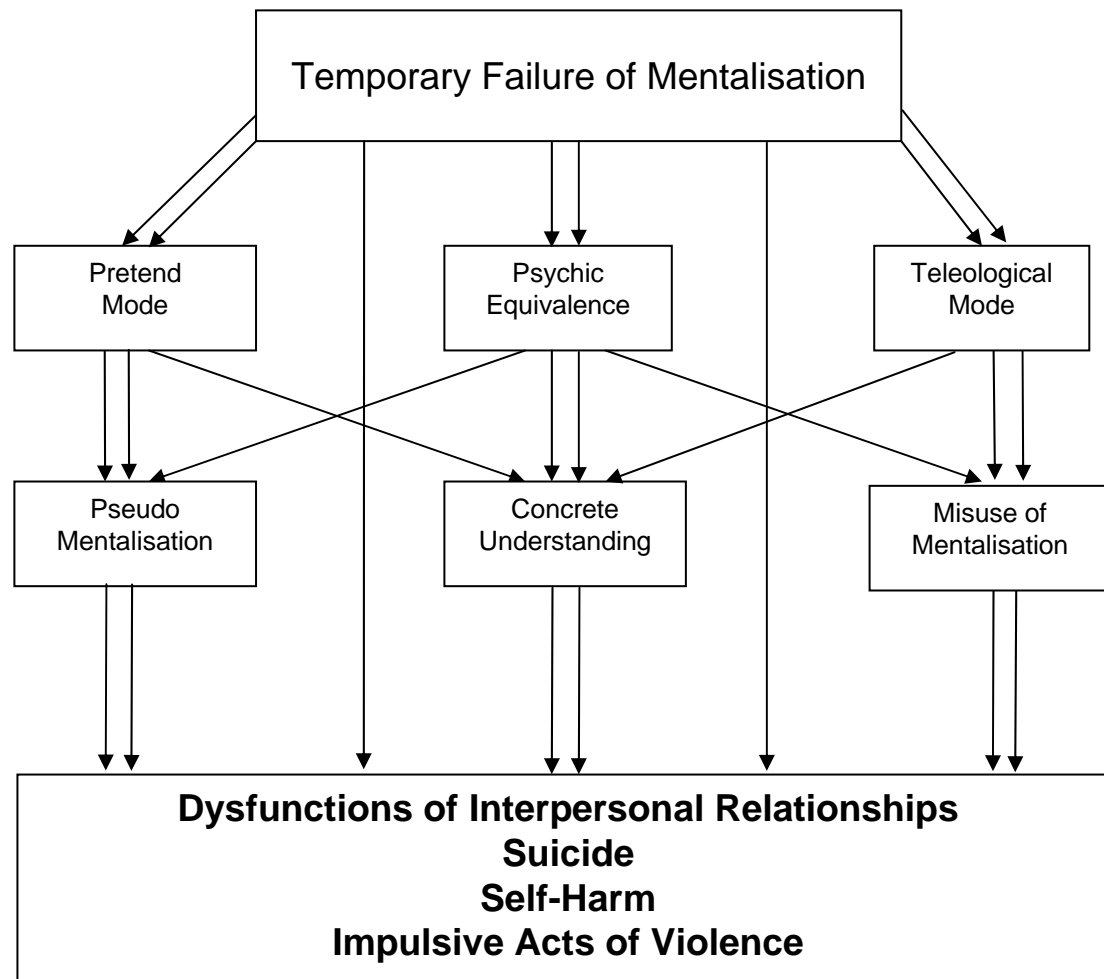
- Ideas form no bridge between inner and outer reality; mental world decoupled from external reality
- Linked with emptiness, meaninglessness and dissociation in the wake of trauma
- Lack of reality of internal experience permits self-mutilation and states of mind where continued existence of mind no longer contingent on continued existence of the physical self
- In therapy endless inconsequential talk of thoughts and feelings
 - The constitutional self is absent → feelings do not accompany thoughts

The Modes of Psychic Reality That Antedate Mentalisation and Characterize Suicide/Self-harm

■ Teleological stance:

- Expectations concerning the agency of the other are present but these are formulated in terms restricted to the physical world
- A focus on understanding actions in terms of their physical as opposed to mental outcomes
- Patients cannot accept anything other than a modification in the realm of the physical as a true index of the intentions of the other.
- Only action that has physical impact is felt to be able to alter mental state in both self and other
 - Manipulative physical acts (self-harm)
 - Demand for acts of demonstration (of affection) by others

Understanding suicide and self-harm in terms of the temporary loss of mentalisation



loss → attachment needs → failure of mentalisation → intensification of unbearable experience → dissociation → teleological solutions to crisis of agentive self

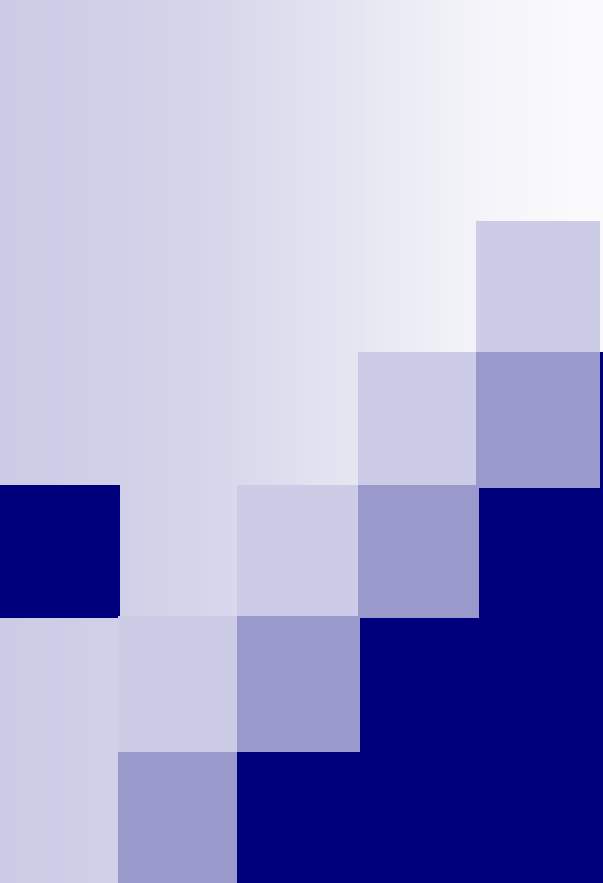
Clinical Vignette

- Patient presents with suicidal ideas
- Assessed as requiring hospital admission
- Agrees to voluntary admission
- Following admission patients wishes to leave
- Detained because of risk
- 2 months later no reduction in risk.
- Further opinion suggested that consideration given to her leaving hospital



Illustrative Clinical Vignette

- Barricades herself in her room
- Police called to get her out – take her to a cell and then return her to hospital
- Clinician states that the patient ‘takes up my whole mental state – awake thinking about her at 5am. No one else will see her. What has gone wrong’.
- Managers suggest that she should continue to be detained.



What would you have
done to manage the
situation better and
why?

What has gone wrong?

- Inadequate assessment of risk
 - Risk aversion in assessing risk
- Long admissions with uncertain purpose
- Detention to manage clinician anxiety rather than the patient – misuse of mental health act
- Relevant investigations not performed because of excessive focus on risk



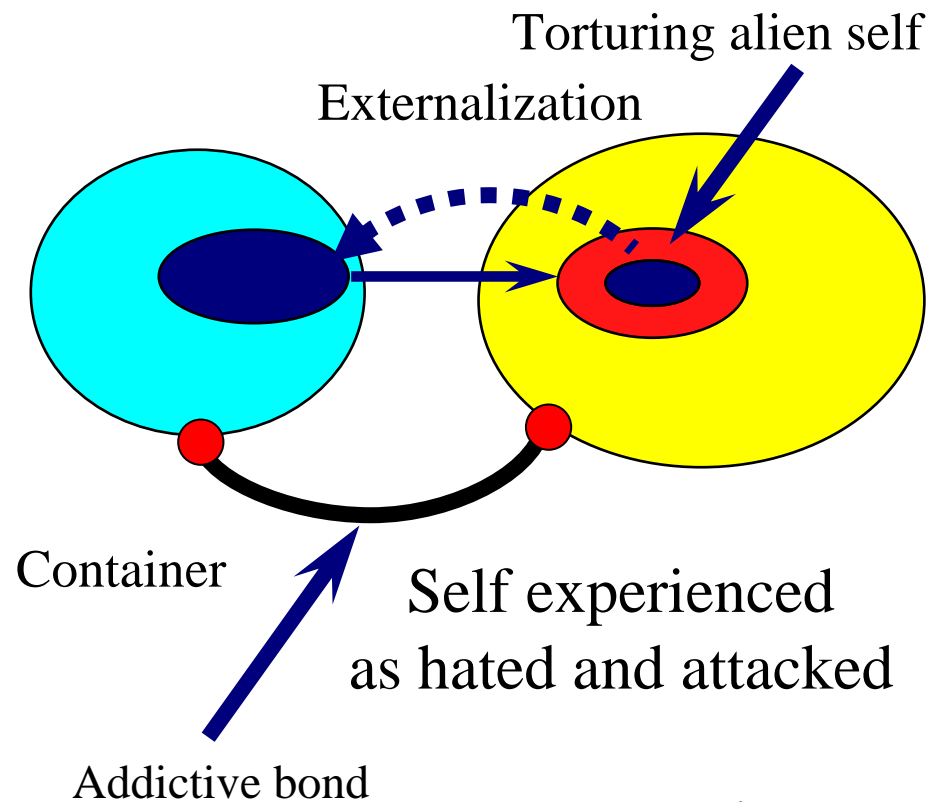
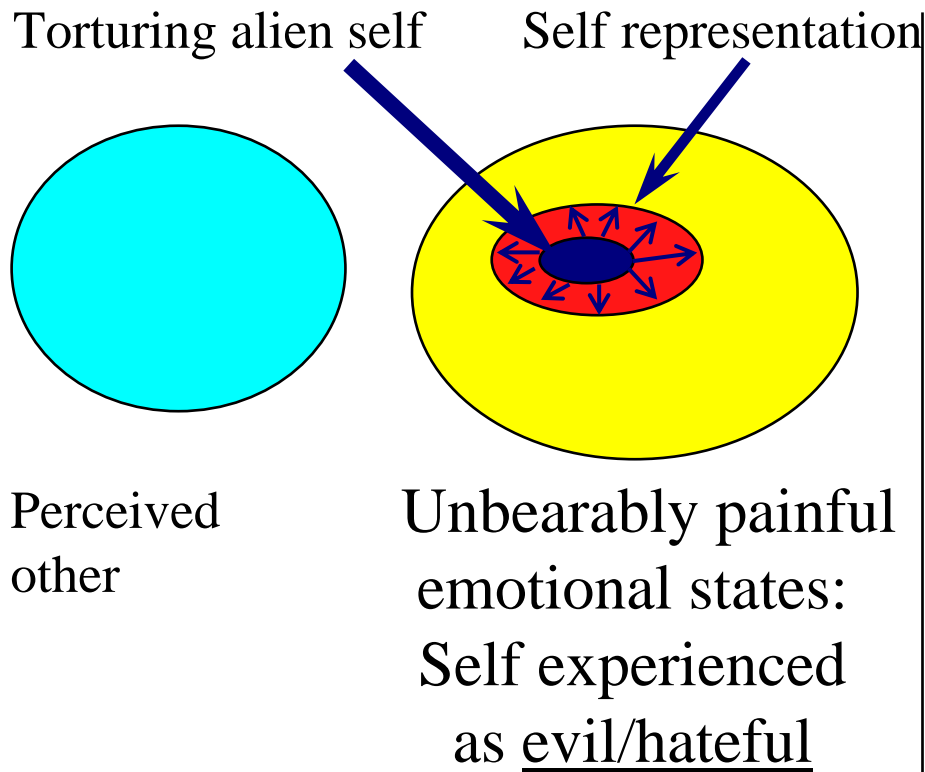
What has gone wrong?

- Mutual teleological stance – show worry by barricading herself in and staff call police.
- Need for consultation – recommends higher risk approach
- Clinician misinterprets consultation and arranges discharge



Mentalising the transference and countertransference


Theory: Self-destructiveness and Externalisation Following Trauma



Self-harm state

Victimized state

Projective identification is used to reduce the experience of unbearably painful emotional state of attack from within – externalisation becomes a matter of life and death and addictive bond and terror of loss of (abusing) object develops



Interventions: Mentalizing the Transference

■ Working in the transference

- Emphasis on current
- Demonstrate alternative perspectives
- Contrast patient's perception of the therapist to self-perception or perception of others in the group
- Link to selected aspects of the treatment situation (to which they may have been sensitised by past experience) or to therapist
- Highlight underlying motivation as evidenced in therapy

Components of mentalizing the transference

- Validation of experience
- Exploration in the current relationship
- Accepting and exploring enactment (therapist contribution, therapist's own distortions)
- Collaboration in arriving at an understanding
- Present an alternative perspective
- Monitor the patient's reaction
- Explore the patient's reaction to the new understanding



Interventions:

Mentalizing the Transference

■ **Dangers of using the transference**

- Avoid interpreting experience as repetition of the past or as a displacement. This simply makes the borderline patient feel that whatever is happening in therapy is unreal
- Thrown into a pretend mode
- Elaborates a fantasy of understanding with therapist
- Little experiential contact with reality
- No generalization

Components of mentalizing the countertransference

- Monitor states of confusion and puzzlement
- Share the experience of not-knowing
- Eschew therapeutic omnipotence
- Attribute negative feelings to the therapy and current situation rather than the patient or therapist (initially)
- Aim at achieving an understanding the source of negativity or excessive concern etc.

Typical Countertransferences

■ Pretend mode

- Boredom, temptation to say something trivial
- Sounding like being on autopilot, tempting to go along
- Lack of appropriate affect modulation (feeling flat, rigid, no contact,)

■ Teleological

- Anxiety
- Wish to DO something (lists, coping strategies)

■ Psychic equivalence

- Puzzlement, confused, unclear, excessive nodding
- Not sure what to say, just going
- Anger with the patient

