HANDBOOK OF MENTALIZATION-BASED TREATMENT

Edited by

Jon G. Allen and Peter Fonagy

John Wiley & Sons, Ltd

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To Yvonne

–J. G. A.

To Fran and Nina

–P. F.

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FOREWORD

Susan W. Coates

What do the following anecdotes have in common?

A boy, observed by Kanner, is enjoying a summer day at the beach. He spots something in the distance that captures his interest. Off he goes, straight toward the goal. But on the way he steps over everything in his path: blankets, newspapers, hands, feet, torsos.

A mother observing a videotape of her son crying is asked what she thinks is going on. She replies, "He always does that, he's OK."

A boy, age 8, notices a scowl on his mother's face and asks, "Mommy are you angry at me or are you just in a bad mood or upset about something else?"

A mother observes a videotape of her daughter at school having a temper tantrum and reflects that she thought her daughter was upset that day because she was getting a cold and was feeling exhausted and sick.

These four disparate anecdotes can be examined from the vantage point provided by the comparatively new concept of "mentalization." The first and second are examples of the absence of mentalization, and the third and fourth indicate high levels of mentalization. Mentalization can be defined as keeping one's own state, desires, and goals in mind as one addresses one's own experience; and keeping another's state, desires, and goals in mind as one interprets his or her behavior. Simply put, each of us has the capacity to be a simple self, a self that experiences the world directly – for example, feels cold, happy, angry, and so forth. But we also can access a more complex self: a self that looks at itself, a self that takes itself as an object of thought and reflection – for example, I see that I was depressed or excited when I said or did such and such a thing. In Jon Allen's apt phrase, mentalization can be thought of as having empathy for oneself.

In the first anecdote, the boy is autistic. His behavior, which utterly though not maliciously disregards the feelings, indeed even the existence, of his fellow beach-goers, is a classic example of what traditionally has been called

"mindblindness." Mindblindness has long been considered a hallmark of autistic functioning, though perhaps this view may need some amending. In any event, mindblindness can be thought of as the opposite of mentalization. In the second anecdote, the mother sees that her son is upset but she negates the meaning of the upset and makes no effort to understand what he is experiencing.

The third anecdote shows that the child understands that his mother's behavior is determined by her state of mind. He recognizes that he cannot know by just looking at her what she is actually feeling. He is concerned that she may be angry at him, but he realizes that her expression may be about something else. In the fourth anecdote, the mother sees that her daughter is upset and works to understand why her daughter's equilibrium might have been undermined by feeling sick that day.

It may be held a virtue of the concept of mentalization that it lends itself to such diverse applications and that in each instance the concept provides an incisive way of looking into the heart of the matter. What additionally makes the new concept so exciting in my view is that it comes to us on the basis of solid, replicable research into fundamental issues in development. I refer here to the broad program of research carried out by Peter Fonagy and his collaborators.

As most prospective readers of this volume undoubtedly know, the origin of the new concept is to be found in the study of attachment. Let me briefly recap the development of modern attachment theory. John Bowlby provided the original theoretical statement of attachment as the fundament for human relatedness. Mary Ainsworth, in turn, invented a novel procedure whereby the status of attachment could be reliably measured in one-year-old toddlers, with the result correlated with maternal behaviors during infancy. Mary Main, in her turn, devised a research instrument, the Adult Attachment Interview, which could predict the quality of the child's attachment on the basis of the parents' individual responses to questions about their parents. Between the contributions of these three seminal figures, it has become possible – indeed necessary – to think of the development of object relations in the child in a multi-generational context that includes the parents and their own remembered experiences. Remarkably, this new body of thought was reliably anchored in empirical studies of great robustness. Thinkers and observers were out of the armchair and into the psychology laboratory and the clinic.

It was in this general context that Peter Fonagy and his collaborators made a startling new discovery. It turns out that mentalization, defined as the capacity to be specifically aware of mental states as such and to use this awareness in regulating affect and negotiating interpersonal relationships, provides a critical link in the transmission of attachment security across generations. That is to say, mothers and fathers who scored high on this dimension on the Adult Attachment Interview tended to have children who were secure. And, importantly, this was

true even though the parents might themselves have had a history of past trauma or current unresolved grief, factors which were otherwise likely to impact negatively on the security of their children. Insight is not only good for you but it is even better for your children.

But there was more. Fonagy and his collaborators had tumbled to something not only important, but generative. It rapidly emerged that secure children in their turn tended to develop the rudiments of the capacity for mentalization faster than did their insecurely attached peers. Quite separately, it also emerged that in adult borderline patients the capacity for mentalization appeared to be severely compromised, and that this deficit could be meaningfully linked to their own history of abuse and neglect as children. Finally, it appeared that the concept of mentalization could be utilized to provide a unique lens for interpreting the data from a large outcome study of the treatment of children conducted at the Anna Freud Centre.

In summary, mentalization has been empirically linked to important findings in development, in the understanding of psychopathology, and in the conceptualization of treatment efficacy for both children and adults – and here I have only mentioned the very first findings of what has become a vast research effort on multiple fronts. What we have here is something of a conceptual revolution, one that is still underway. The prospects for further research and exploration are truly exciting. In this volume distinguished clinicians take the next step to explore the usefulness of the concept of mentalization to clinical work in a broad spectrum of settings and in relation to varieties of clinical challenges. I expect the reader of this volume will be as tantalized as I have been by the important new vistas that their contributions open up.

PREFACE

Jon G. Allen and Peter Fonagy

In advocating mentalization-based treatment we claim no innovation. On the contrary, mentalization-based treatment is the least novel therapeutic approach imaginable: it addresses the bedrock human capacity to apprehend mind as such. Holding mind in mind is as ancient as human relatedness and self-awareness. Nonetheless, fostering the capacity to mentalize might be our most profound therapeutic endeavor: cultivating a fully functioning mind is a high aspiration indeed.

Might we claim that *all* psychotherapy is mentalization-based treatment? Hardly. This would be akin to the claim that all therapy that influences behavior is behavior therapy, that all therapy that influences thinking is cognitive therapy, or that all therapy that influences intrapsychic conflict is psychodynamic psychotherapy. All therapy requires mentalizing on the part of the patient and the therapist; mentalization-based *treatment* entails explicit attention to mentalizing in the therapeutic process; and mentalization-based *therapy* structures attention to mentalizing through specific therapist training and treatment manuals. This volume aims to interest clinicians of diverse theoretical orientations in mentalization-based treatment and to acquaint them with mentalization-based therapy.

The concept of mentalization emerged in the psychoanalytic literature in the late 1960s but diversified in the early 1990s when Simon Baron-Cohen, Chris Frith, and others applied it to neurobiologically based deficits in autism and schizophrenia and, concomitantly, Peter Fonagy and his colleagues applied it to developmental psychopathology in the context of attachment relationships gone awry. This volume reviews work in the latter tradition, wherein mentalizing is construed as a dynamic skill, the performance of which is compromised, for example, in the context of intense affects associated with conflicts in attachment relationships.

Following the principle that psychotherapeutic interventions be tailored directly to psychopathological processes, mentalization-based therapy was first developed and researched in the treatment of individuals with borderline personality disorder, a condition that often develops in conjunction with trauma in attachment

relationships. More recently, befitting its developmental origins, mentalization-based therapy is being applied to families and mother-infant dyads. Currently, we are expanding the realm of mentalization-based treatment, exemplified by programs at The Menninger Clinic, which specializes in time-limited inpatient treatment for patients with heterogeneous treatment-resistant psychopathology. We are promoting a cohesive conceptual framework throughout the clinical services by employing attachment theory and the concept of mentalizing. In the process, we are educating staff members, patients, and their family members about mentalizing such that the word is becoming part of everyday parlance. But this aspiration for conceptual cohesiveness faces the challenge of integrating mentalizing with what is perforce an eclectic treatment program that includes psychopharmacology, a therapeutic milieu, individual and group psychotherapy, as well as cognitive behavior therapy and dialectical behavior therapy, all implemented by a multi-professional team with the patient at the center. Thus this volume evolved from the authors' collective experience in employing the concept of mentalizing to assist in understanding diverse forms of psychopathology as well as our experience in conducting a range of mentalization-based interventions and our ever-expanding experience in educating mental health professionals and consumers alike.

While mentalizing is a basic human capacity that we generally take for granted, the concept is surprisingly hard to pin down. Thus, in Part I, "Conceptual and Clinical Foundations," Jon Allen's chapter launches the volume by explicating the concept and its distinctiveness from related terms. Jeremy Holmes continues this clarification in a chapter articulating the place of mentalizing in psychoanalytic theory where it remains rooted.

In launching Part II, "Developmental Psychopathology," Peter Fonagy's chapter establishes the scientific foundation for mentalization-based treatment. Fonagy ensconces an integrative neurobiological theory of mentalizing in an evolutionary framework as a prelude to reviewing research on the development of mentalizing in the attachment context and in social relationships more generally. Carla Sharp's chapter follows naturally, reviewing contemporary research to show how childhood psychopathology can be understood through the lens of mentalizing deficits, in the course of which she delineates different forms of mentalizing impairments. Glen Gabbard's chapter concludes this section by explaining how neurobiological research enhances our understanding of mentalizing deficits in the development and treatment of borderline personality disorder.

Part III, "Incorporating Mentalizing in Established Treatments," illustrates how explicit attention to mentalizing can be integrated into different therapeutic approaches. Richard Munich shows how a focus on mentalizing can be incorporated into psychodynamic psychotherapy, poignantly illustrated by a particularly challenging interaction with a treatment-resistant patient. Thröstur Björgvinsson and John Hart systematically address a common question: how does mentalization

relate to cognitive therapy? Continuing in this vein, Lisa Lewis's chapter forges links between mentalizing and dialectical behavior therapy skills training as enhanced by interventions from positive psychology.

Part IV, "Mentalization-based Therapy," presents a range of applications wherein mentalizing is a relatively exclusive focus of treatment. The section fittingly begins with the developmental roots of mentalization-based therapy, Anthony Bateman and Peter Fonagy's evidence-based treatment program for persons with borderline personality disorder. The section continues with the next developmental step, Short-term Mentalization and Relational Therapy (SMART), an integrative approach to family therapy for children and adolescents. Pasco Fearon and colleagues' chapter summarizing the treatment approach is followed by Laurel Williams and colleagues' discussion of the challenges in training therapists to conduct mentalization-based therapy. Next, Efrain Bleiberg's chapter conveys the benefits of employing mentalizing as a conceptual framework for a specialized inpatient program for professionals in crisis. The section concludes with Toby Haslam-Hopwood and colleagues' chapter describing their psycho-educational program designed to foster a therapeutic alliance in mentalization-based treatment by explaining the concept to patients and their family members – an endeavor that is having the unanticipated benefit of clarifying the concept for the authors.

The concluding section, "Prevention," illustrates the broader social implications of problems in mentalizing. Lois Sadler and colleagues summarize their pioneering work in helping mothers engage in mentalizing interactions with their at-risk infants to provide a foundation in attachment that will initiate a more positive developmental trajectory. Stuart Twemlow and Peter Fonagy describe a school-based program that effectively decreased bullying by enhancing mentalizing at a social-system level. The volume concludes with Helen Stein's chapter employing a research-based case study to illustrate the whole point of mentalization-based treatment: promoting resilience.

We are in the fortunate position to present these clinical applications of mentalization-based treatment by virtue of more than a decade-long international collaboration of colleagues in the Child and Family Program, the brain child of Efrain Bleiberg which Peter Fonagy and Jon Allen were privileged to lead in its formative years when The Menninger Clinic remained in Topeka, Kansas. Now, in the context of the clinic's relocation to Houston, Texas, the Child and Family Program is flourishing in the context of a consortium of extraordinarily supportive and intellectually stimulating institutions: the Anna Freud Centre, University College London, the Yale Child Study Center, the Menninger Department of Psychiatry and Behavioral Sciences at the Baylor College of Medicine, and The Menninger Clinic. This work would not have been possible without the administrative support of these institutions and innumerable collaborators whom the contributors to this volume are proud to represent.

PART I

CONCEPTUAL AND CLINICAL FOUNDATIONS

1

MENTALIZING IN PRACTICE

Jon G. Allen

I will need this entire chapter to explicate the concept of mentalizing (Fonagy, 1991), but we can get started with the idea of attending to states of mind in oneself and others – in Peter Fonagy's apt phrase, holding mind in mind. I had been working intellectually with this concept for many months before I noticed how it was influencing the way I was conducting psychotherapy with traumatized patients. I remember the session in which theory and practice came together in my mind:

> The patient, a man in his mid-forties, had been hospitalized for treatment of depression and panic attacks associated with intrusive posttraumatic memories stemming from sexual assaults in his childhood. A much older neighborhood boy had tormented and terrorized him. The patient characterized this older boy as being "wild-eyed and crazy," and the patient had been utterly convinced that his tormentor would follow through on his threat to set the family's house on fire if he were to tell his parents about the abuse.
>
> Profoundly ashamed, the patient had not told anyone about the experience, and he had largely succeeded in putting it out of mind. Although he had struggled with depression episodically throughout his adult life, he had maintained loving relationships with his wife and three children, and he had become a partner in a highly successful medical practice. All went well until he was blindsided by what he perceived to be a frivolous lawsuit, which turned out to be a nightmare. The aggressive legal scrutiny of his practice that ensued led him to feel as if he were being "raped." Only after weeks of a downhill slide did he associate this intrusive psychological assault in adulthood with his childhood trauma.
>
> Naturally, the patient had been doing everything possible to block the traumatic images and associated body sensations from his mind – including abusing alcohol

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and sleeping medicine, which only exacerbated his growing depression. As his avoidant defenses gradually eroded, the intrusive childhood memories came to the fore. But these memories had an unreal quality that made them even more disturbing. The patient wanted my help in getting rid of these memories. How was I to proceed?

As trauma therapists of many theoretical persuasions would have done, I asked him to talk through the particular childhood assault he remembered most clearly; he did so without undue anxiety, but he was dissociatively detached from the memory. As many therapists might have done, I asked him to tell it again as if it were happening to him at the moment. He recounted the event far more emotionally and, afterward, indicated that the experience had taken on a greater sense of reality. Remembering was painful, but not overwhelming. He was able to calm himself by imagining that he was sitting on a boulder overlooking a mountain range.

At this juncture, the point of mentalizing became clearer to me: rather than putting the traumatic memories *out* of mind, the patient would be better served by being able to have the memories *in* mind – as emotionally bearable and meaningful experience, albeit unpleasant and painful. Hence, I suggested that he change strategies: rather than endeavoring to avoid thinking about the traumatic event, he could practice bringing it to mind deliberately without becoming too immersed in it, and then he could use his comforting imagery to relax and put the memory out of mind. He was able to do so and, in the process, developed a sense of control over his mind. Thereafter, rather than being blindsided and panicked by the intrusion of the memory, when the inevitable happened and something reminded him of the trauma, he was able to tolerate the images, work with them, and put them out of mind. He no longer feared his own mind, as patients with posttraumatic stress disorder invariably do; rather, he developed a sense of confidence that he could cope with whatever came to mind.

I would characterize my therapeutic intervention as an exposure-based procedure (Foa & Kozak, 1986), but I now prefer to conceptualize the process as assisting the patient to mentalize rather than merely "desensitizing" him, an unduly passive concept. Desensitization entails new learning: the patient becomes desensitized by virtue of engaging in the active work of mastery through mentalizing.

Another example typical of trauma treatment:

A woman in her early thirties was hospitalized in the aftermath of a suicide attempt precipitated by her husband's announcing his intention to file for divorce after he ultimately became fed up with her abusive rages. Her parents had divorced when she was eight years old. She lived with her mother for several months afterwards, but her father fought for custody after her mother's depression and alcohol abuse escalated to the point that the patient was seriously neglected. For the patient, the situation went from bad to worse. Her father had remarried quickly after the divorce; the patient's stepmother was resentful of her presence; and the stepmother became increasingly abusive psychologically and physically. As her father's new marriage deteriorated, he spent more time away from the home. As resentful as she had become of her mother, the patient berated her for being "palmed off" on

her father while simultaneously pleading with her mother to take her back. Her mother consistently refused.

The patient was talented and engaging and, despite this history of attachment trauma, she did not give up on seeking attachments. She was able to maintain solid friendships and supportive relationships with teachers and coaches. She earned a university scholarship, enabling her to leave home at the first opportunity. She married soon after graduation, indicating in the psychotherapy that her husband had appealed to her as a "strong, silent type" – a protector. The "silent" facet proved to be the bane of her marriage; she came to experience her husband as emotionally unavailable, and she felt emotionally neglected. Predictably, the more antagonistically she voiced her resentment, the more her husband withdrew. The patient's behavior became increasingly regressive – downright childlike in her tearful tantrums. Her husband ultimately had enough and planned to end the marriage.

Before I began working with her in the inpatient context, the patient had been in an outpatient psychotherapy process in which she became immersed in reviewing traumatic memories. Unfortunately, this process only seemed to escalate her distress, and her functioning continued to deteriorate. I began working with her in psychotherapy soon after she was hospitalized, and it was apparent that, in light of her regressed functioning, the whole treatment should focus on containment – developing emotion-regulation skills and supportive relationships – rather than further processing traumatic memories. Initially, the patient agreed wholeheartedly with this approach; she was overwrought and exhausted, in part from the previous expressive therapy. Unsurprisingly, her enthusiasm for the process waned as I gently encouraged her to contain her emotions and to focus on coping in the present. Instead, she wanted the consolation she had not received in childhood; indeed, she angrily demanded it.

Plainly, rather than working on the trauma therapeutically, the patient had been re-enacting her traumatic past in her current relationships, with her husband and in the therapy as I, too, seemed emotionally unavailable. The hospital treatment provided an opportunity not only for individual psychotherapy but also for family work to address ongoing problems with her husband and her parents. All this work was sustained by nursing care that supported more adaptive functioning. Confronting her pattern of re-enactment both in the family work and in the individual psychotherapy enabled her to perceive and understand how, unwittingly, she had been undermining the attachments she so desperately needed. Concomitantly, a small shift on both her parents' part enabled the patient to feel "heard" for the first time in her memory. Gradually, the patient learned to express her feelings and assert her needs more effectively, and she moved toward reconciliation with her husband.

Again, there is nothing unusual in this therapeutic approach. I was guided by my belief that symptoms of posttraumatic stress disorder are evoked and maintained by re-enactments of traumatic relationship patterns: these re-enactments evoke the reminders that trigger posttraumatic intrusive memories (Allen, 2005a). The alternative to re-enactment is mentalizing, that is, developing awareness of the connections between triggering events in current attachment relationships and

previous traumatic experiences. No less important is the other side of mentalizing: cultivating awareness of the impact of one's behavior on attachment figures.

Of course Freud (1914–1958) could have explained all this to me about a century ago; in promoting mentalizing, I was striving to help my patient remember rather than repeat. Engaging in some amalgam of exposure therapy and psychodynamic psychotherapy, I have not introduced any novel techniques or interventions. Nonetheless, employing the concept of mentalizing has clarified my thinking about what I am doing, bolstered my sense of conviction in the process, and perhaps thereby contributed to my effectiveness in subtle ways.

On the face of it, enjoining mental health professionals to attend to the mental seems absurdly unnecessary. Yet, in light of the increasing hegemony of biological psychiatry with the associated increase in reliance on medication and the concomitant decline in use of psychotherapy (Olfson et al., 2002), we should not underestimate the value of reiterating the obvious: we must keep mind in mind. But we must do more than re-invigorate a waning tradition. On closer inspection, the ostensibly plain concept of mentalizing turns out to be highly complex and invariably confusing, as we continually rediscover in striving to explain it to patients – our best critics (see Haslam-Hopwood and colleagues, Chapter 13). The conundrum, as Dennett (1987) rightly mused: "[H]ow could anything be more familiar, and at the same time more weird, than a mind?" (p. 2). Undaunted, we proceed in the spirit Searle (2004) advocated: "Philosophy begins with a sense of mystery and wonder at what any sane person regards as too obvious to worry about" (p. 160).

This chapter first defines mentalizing and explicates its daunting conceptual heterogeneity; second, sharpens the concept of mentalizing by contrasting it with several related terms; third, highlights the conditions that facilitate mentalizing in clinical practice; fourth, having placed the cart squarely before the horse, makes the case for the value of mentalizing; and, lastly, defends the word.

MENTALIZING IN ACTION

Familiar yet slippery, our concept of mentalizing tends to become all-encompassing, potentially extending beyond manageable bounds. Mentalizing pertains to a vast array of mental states: desires, needs, feelings, thoughts, beliefs, reasons, hallucinations, and dreams, to name just a few. Mentalizing pertains to such states not only in oneself but also in other persons – as well as nonhuman animals, for that matter. And, as a mental activity, mentalizing includes a wide range of cognitive operations pertaining to mental states, including attending, perceiving, recognizing, describing, interpreting, inferring, imagining, simulating, remembering, reflecting, and anticipating.