Mentalization-based Therapeutic Interventions for Families

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This article attempts to bridge two seemingly different and yet related worlds, the intra-psychic and the interpersonal, by viewing systemic practice(s) through a mentalization-based lens. It is argued that in therapy there needs to be a deliberate, conscious and consistent focus on mentalizing. The emerging mentalization-based therapy for families is an innovative approach and a distinctive model which is systemic in essence, deriving its ideas and practices from a variety of diverse systemic approaches, yet enriching family work by adding mentalizing ingredients.

Keywords: mentalization based psychotherapy; mentalization based family therapy.

Introduction

The terms ‘mentalization’ and ‘mentalizing’ are often used interchangeably. The latter, derived from the verb ‘to mentalize’, perhaps better captures the idea that we are concerned with an ongoing activity rather than with a fixed state of mind or an individual characteristic. Mentalizing is a process and it generally occurs without effort or specific consciousness. It can be summarized as seeing ourselves from the outside and seeing others from the inside. Mentalizing (Fonagy \textit{et al.}, 1991) refers to the attitude and skills involved in understanding mental states (one’s own as well as those of others) and their connections with feelings and behaviour. The recursive character of this process – the interlinking of mental states and the way in which they continuously influence each other – would seem to recommend it to a systemic approach. In this article we argue that employing a mentalizing lens when undertaking systemic work has the potential to enrich practice. The emerging approach of mentalization-based therapy for families (MBT-F) (for example,
Asen and Fonagy, 2011; Fearon et al., 2006) is placed within the context of systemic work and the reader is encouraged to consider whether it is an altogether new way of working or merely an addition to familiar systemic approaches. Throughout our collaboration we have been struck by features common to both approaches. Here we consider MBT-F from a systemic perspective.

Systemic practice has undergone many changes over the past 60 years. The self of the therapist has come into focus (Rober, 1999) and, in line with this, systemic practitioners have begun to link the intra-personal and interpersonal worlds (Flaskas, 2002; Fraenkel and Pinsof, 2001). Mentalization-based work with individuals diagnosed with borderline personality disorder (Bateman and Fonagy, 2006) awakened in systemic therapists an interest in the concept of mentalizing. In turn, clinicians involved in developing mentalization-based approaches could see that they had much in common with their systemic colleagues. This is how the development of MBT-F began a few years ago.

The mentalizing background

No animal, not even the most intelligent of non-human primates, can discern whether an other’s acts are due to chance or are rooted in intention, wish, belief and desire. By contrast, humans automatically and without reflection seek to attribute to acting individuals mental states that might have motivated their actions. Making such attributions is an essential form of mentalizing. It has also been argued that this capacity to mentalize, which is gradually developed from infancy onwards through interaction with the primary caregiver(s), accounts for further major differences between humans and other apes (such as the fact that only humans have self-awareness and self-consciousness). It could be said that we needed to be self-aware in order to understand others through simulation (Gordon, 1986, 1987; Harris, 2009). Similarly, to anticipate someone’s actions we may imagine ourselves into their position; for this, too, we need self-awareness (which is essentially mentalizing applied to oneself). The awareness of mental states brings with it valuable social emotions such as embarrassment, shame and guilt. More positively, conceiving of mind perhaps enabled humans to strive to be more than beasts, to live beyond their body, to aspire to a spirit that transcends physical reality and to step beyond their own physical existence. Also in line with systemic thinking, the focus on mental states as the generators of behaviour brings into relief
the social origin of the self: the recognition of oneself in the mental state of the other lies at the root of the sense of personal selfhood (see Allen et al., 2008 for a more comprehensive review of the concept).

An adequate perception of one’s own state is evidently essential for a balanced inner life. One can experience a loss of calibration of internal experience (that is, not knowing how seriously to take one’s own subjectivity) as mental disorder. It should be emphasized, however, that effective mentalizing is not only the capacity to read accurately one’s own or another person’s states of mind, thoughts and feelings. It also refers to a way of approaching relationships that reflects an expectation that one’s own thinking and feelings may be enriched and changed through learning about the mental states of other people and through a readiness to take into account their perspectives, needs and feelings. This attitude is characterized by an inquiring and respectful stance in relation to other people’s mental states. This is akin to the systemic stance of ‘curiosity’ (Cecchin, 1987). Both stances involve an awareness of the limits of one’s knowledge of others.

Mentalizing is, by definition, inexact. Developing an accurate picture of others’ states of mind requires constant social verification. Mentalizing is developmental, increasingly complex and only gradually achieved. Orientation to other minds is part of the behavioural repertoire of all infants and the developmental pathway of mentalizing is reasonably well charted (Sharp et al., 2008). The increasing sophistication of mentalizing with age speaks to the complexity of the process. It is important to keep in mind this multifaceted nature of mentalizing when applying it in therapeutic work.

The development of mentalizing capacity occurs in the context of attachment relationships. Disruptions of attachment can create developmental vulnerabilities that lead to shortcomings in complex metacognitive capacities (Fonagy and Target, 1997). However, the relationship between attachment and mentalizing is bidirectional: attentional problems, the inability to represent the mental state of the self and difficulties in reflecting on the mental states of others can disrupt attachment relationships; and a poor attachment relationship undermines the natural emergence of mentalizing capacities (Fonagy and Luyten, 2009). The child who is better understood will understand the parents better. Their resulting interactions will be more readily understood by the parent, which will in turn enhance the child’s mentalizing capacities. This is a circular process that is very much in line with systemic thinking. Setting aside reductive causal models, we see the family system as providing critical components of the content
such as understandings of specific feelings and thoughts) required for the healthy development of mentalizing. Children’s evolving capacities can be facilitated or hindered by their relationships with attachment figures and by the relationships they observe between family members.

**Effective mentalization**

MBT-F is based on the idea that effective mentalizing needs to be strengthened by being identified, validated and developed (Allen et al., 2008). Here, we describe several mentalizing strengths that MBT-F aims to promote and we link these to systemic techniques and (implicit) objectives.

*Openness to discovery* is similar to what systemic therapists call curiosity (Cecchin, 1987). In MBT-F this refers to an attitude in which the individual is genuinely interested in other people’s thoughts and feelings and respects the perspectives of others. It includes a reluctance to make assumptions or hold prejudices about what others think or feel.

The *opaqueness of mental states* (Leslie, 1987) is a similar concept to that of safe uncertainty (Mason, 1993) and implies the open acknowledgment by the good mentalizer that one can never know but can only guess what other people are thinking. It is safe, in that this stance does not lead to the individual becoming totally perplexed or overwhelmed by what may happen in the minds of others. This confidence is based on a background feeling that the reactions of others are at least to some extent predictable, given the sense one has of what others may think and feel.

*Reflective contemplation* is a mentalizing attitude that conveys a flexible, relaxed and open attitude, rather than a controlled and compulsive pursuit of how others think and feel. The reflecting team techniques (Andersen, 1987) capture and enhance this mentalizing strength.

*Perspective-taking* is characterized by the acceptance that the same phenomenon or process can look very different from different perspectives and that these tend to reflect individuals’ different experiences and histories. The technique of circular and reflexive interviewing (Selvini Palazzoli et al., 1980) has a similar effect of generating multiple perspectives.

There is no obvious systemic equivalent to the notion of *forgiveness*, a mentalizing strength that bases the comprehension of the actions of
others on the understanding and acceptance of their mental states. An example of this is the management, if not dissipation, of one’s own anger towards a person who was offensive, once one has understood that the other person acted as they did because of, say, a significant personal loss.

Impact awareness is another important aspect of successful mentalizing: it refers to the appreciation of how one’s own thoughts, feelings and actions may affect others. Systemic practitioners tend to use tracking questions to generate impact awareness.

Having a trusting attitude is an important mentalizing strength and it is in marked contrast to a paranoid, fearful stance that may be incompatible with accurate mentalizing. Systemic practitioners subscribe to a stance of transparency and authenticity and may employ a variety of joining techniques (Minuchin, 1974) to generate a context of mutual trust in the therapeutic setting.

Humility (moderation) in relation to one’s capacity to know and understand someone else and willingness therefore to be surprised and learn from others, regardless of status, follows from many of the strengths described above. Systemic practitioners have adopted the ‘one down’ position which, if employed in an authentic and not strategic way, is similar to a stance of humility.

Playfulness and (self-mocking) humour gently force alternative perspectives and can also lead to give and take in interactions with family members and significant others. Systemic practitioners use humour and playfulness to get family members to look at and experience themselves in fresh contexts.

The belief in changeability implies some degree of optimism and embodies the hope that minds can change as well as physical situations. This is analogous to the inappropriateness, within the systemic frame of reference, of talking about a treatment-resistant family.

The strengths of assuming responsibility and accepting accountability are also embraced by the systemic field. In MBT-F they originate from the recognition that one’s actions are generated by one’s own thoughts, feelings, wishes, beliefs and desires – whether one is fully conscious of them at the time of the action or not. MBT-F therapists would not shy away from challenging individuals to examine their contribution to specific states of affairs (for example, relationship issues) whereas systemic practitioners might seek explanations in the individual’s context, whether it is their family, social or cultural setting. An MBT-F therapist may, under certain circumstances, view this as a non-mentalizing stance to adopt.
Systemic difficulties in mentalizing terms

As well as enhancing effective mentalization, MBT-F also aims to address the difficulties in mentalizing that contribute to relationship problems. The overarching assumption of MBT-F is that difficulties in mentalizing have a pervasive impact on a family’s capacity to function effectively, since feeling misunderstood has the potential to create acute distress and chronic distortions of relationships. Even in the same family, mentalizing problems will emerge in different forms and with differing degrees of severity at different times and in particular situations. Difficulties may be relatively mild and specific but can also include non-mentalizing attitudes that have long-term effects on the well-being of individuals and their families. Mentalizing strategies may also be under-used or applied erratically because of demands external to the family or high levels of perceived stress. This can also be the case if a family member or a relationship has a particular blind spot. At the more extreme end of the spectrum, one or more family members may deliberately or inadvertently misuse mentalization in their dealings with others. While taking note of such impairments of mentalization, MBT-F nevertheless focuses primarily on enhancing mentalizing strengths. It does not concern itself with dissecting pathological mentalization patterns; nor does it target specific examples of dysfunctional mentalization with the aim of modifying particular patterns of cognition (as might be the case for cognitive behavioural approaches).

In the course of MBT-F we intervene when we sense mentalization difficulties in one or more members of the family. We anticipate that strengthening mentalization will promote change in interpersonal perception and interaction. For example, we may be working with a family in the midst of an acrimonious parental separation and observe that one parent, who is otherwise highly sensitive to their children’s feeling states, finds it particularly hard to tune into one child’s thoughts and feelings about the loss of the parental couple (perhaps because of ongoing conflict with the partner). In this situation, we would encourage each family member to speculate about the child’s feelings and thoughts. It may emerge that one of the parents is unable to mentalize that aspect of the child’s internal world. Other family members will be invited to contemplate why this parent appears to be so blocked, and particularly encouraged to think about the feelings that may have been evoked in the person by the challenging family situation. Throughout this process, each family member is also
implicitly required to reflect on their own mental experience through their engagement in the task of simulating the emotional experience of another family member. We consider this development of a more accurate perception of one’s own mental states, and of the mental states of others, the essence of the benign recursive process of MBT-F. The aim of interventions is to promote the quality of mentalizing (by which we mean accuracy, depth and robustness, as well as richness and creativity) in the whole family.

Difficulties in mentalizing are most commonly indicators of some form of stress. Whatever the nature of the pressure on the family and its individual members, most people will temporarily lose their capacity to think about the thoughts and feelings of others when functioning in a fight–flight mode (Luyten et al., 2009). For example, quite dramatic temporary failures of mentalization can arise in individuals and families during emotionally intense interchanges. This can also happen merely in response to thoughts and feelings that trigger high arousal and non-mentalizing concrete reactions.

Under such circumstances, high levels of arousal ‘turn off the prefrontal cortex’, which normally mediates this psychological capacity (Arnsten, 1998, p. 1711). This drastically limits the ability to check and evaluate one’s own mental states, and can cause grossly inaccurate or even malevolent feelings to be attributed to others. As a result, feelings of resentment and mistrust can develop in the relationship context. This, in turn, increases arousal and sets in motion a negative circular process. Ultimately, the representation of the minds of others can literally be obliterated and replaced by empty or hostile schematic images.

In a contact dispute between two estranged parents, for example, a parent can become convinced that his/her child is siding with the other parent and is being deliberately and maliciously provocative. Disastrously, the parent’s mind all too often becomes incapable of seeing the child in any other way. This can force the child to behave according to this script, just in order to feel that he/she is being seen. As another example: an adult who suffered physical and sexual abuse in childhood, when faced with a reminder of past trauma, may experience intense states of helplessness, anger or shame and temporarily have difficulties mentalizing. Or, a mother’s state of mind may be triggered by something her child has said (for example, ‘Mummy, why are you looking at me like that?’). Her dissociative presentation may be experienced by the child as emotional unavailability, and this may generate powerful distress in him (Lyons-Ruth
and Jacobovitz, 2008). This in turn intensifies the mother’s trauma-tized dissociative reaction and her traumatic non-mentalizing stance. A child who generally has good experiences of feeling thought about and understood may be confused by his parent’s sudden inability to appreciate his disappointment and bewilderment.

Other specific family problems of mentalizing can arise if individuals obscure their own mental states and thus make it difficult for others to inquire about and understand their states of mind. One example of this was a 9-year-old girl whose father had died and whose mother was struggling with her own bereavement. The mother, who had found a new partner, deliberately avoided contemplating the father. The child may have felt a strong urge to keep secret her positive feelings for her father and thus may have tried to manage her distress about the loss on her own. The child sensed the mother’s need to be protected from the intensity of her own feelings of loss. In doing so, the child hid her own feelings and put on a mask of cheerful competence. This made it impossible for the mother to tune into her child’s sadness and left the daughter with a sense that she was not understood at all. This circular process illustrates how a systemic issue can be illuminated and elaborated from a mentalizing perspective.

Long-standing and severe mental health problems can compromise mentalizing in families in a number of ways. A parent with schizophrenia may, during acute episodes of ill health, present with strong unshakable beliefs that will impede his curiosity and reflective contemplation (Cooklin, 2010). He may also find it difficult to see things from others’ perspectives and to be trusting. A child may respond by becoming an unusually good mentalizer, anticipating problematic situations for the parent and steering the parent around them. Being a precocious mentalizer can put children on track to becoming young carers. Another response is for the child to seemingly disengage from the mental state of the parent and this stance can generalize to being apparently unconcerned about other adults. In both situations the parent’s interest in the child’s mental state decreases as a consequence. When a parent has major depression, the child may become overactive in an effort to provide stimulation for the parent. These efforts are profoundly limited as the child is unable to simulate the parent’s mental state, which is far beyond the child’s range of subjective experience. The child cannot put himself in his parent’s shoes and, as his genuine capacity to simulate the parent’s state of mind is curtailed, he will engage in imaginative but unrealistic and unhelpful fantasies about the parent’s subjective experience (what is...
referred to as hypermentalization or the pretend mode in Fonagy and Target (2000). The opposite response is that the child adopts, as the least painful way of coping with what may well be an experience of emotional neglect, a stance analogous to that of the parent: the child shuts down and opts not to think about the parent’s possible intentional states.

In many instances of long-term and enduring mental illness, a dependent child’s need to be thought about as thinking and feeling is not adequately met because the child has to compensate for the parent’s limited ability to mentalize the child. As a result, the child may become excessively concerned with mental states in general and embark on a pseudo-career as a little psychologist (pseudo-mentalizing) but without the experience of life that would give the attempt at mentalizing substance. In their preoccupation with the mental states of others, these children, who may often be described as young carers, achieve hyper-reflectiveness about others. But this comes at the expense of their self-reflection. This leads such children to deny their own intense feelings. For example, a 12-year old boy to whom it was suggested that he must have had plenty of feelings of anger because of being let down by his unwell mother, replied, very angrily, ‘I have never felt angry in my whole life’. Children who excessively mentalize about others often face long-term social and developmental difficulties.

Parents prone to experiencing high levels of arousal, such as those with high trait anxiety or those prone to emotional storms, can find themselves excessively engaged with the child’s mental world, anxiously loading the child with their own preoccupations. The child, who does not understand the source of severe parental anxiety, will be perturbed by it. He/she will search for an explanation in the parents’ actions and thoughts by engaging in excessive mentalizing. In a sense, parallel processes take place in the parent and child, although the processes fail directly to inform each other.

When these unacknowledged interactions take place in a family context, they have an inevitable impact on everyone, generating intense but disconnected efforts all around to mentalize what is occurring. In a family session in which two people are involved in a dyadic interaction and are attempting to drive home their respective points without the ‘curiosity’ that might make the interaction genuinely productive, a child may become paralyzed and stop thinking. Often, there will be an attempt by each of the dyad to draw in either the child or the therapist to validate his/her perceptions of the other dyad member’s mental states. Because the child and the
The therapist can have only partial understandings (if that) of the states of mind of the dyad members, they are each at risk of being recruited into a potentially non-mentalizing interaction. In this way, a non-mentalizing dyad becomes a triad. The therapist is likely to understand only some aspects of the interaction and, in turn, the agonists will have only selective understandings of the therapist’s stance (in all likelihood, the ones which best correspond to their respective positions). At the same time, each person in the dyad will feel invalidated by the therapist’s descriptions of the mind state of the other dyad member and feel that they are being sided against. This leads each person, in a desperate attempt to have his/her views accepted, to state his/her position more and more loudly. The noise generated makes it increasingly unlikely that anyone within the system can be receptive to others’ perspectives. Gradually, the system can recruit more and more members of the family, as well as professionals, with an ever increasing number of disconnected minds. This is a mentalizing account of ‘symmetrical escalations’ (Watzlawick et al., 1974), which so often undermine mentalizing capacity in the helping systems that proliferate around families. Just as mentalizing engenders more mentalizing, so non-mentalizing is infectious – it breeds non-mentalizing systems. Awareness of this risk is a powerful source of therapeutic self-protection.

If a member of the family ‘leaves the field’ and becomes unavailable for mentalizing, other family members may show even more extreme ways of non-mentalizing, taking on a stance that directly attacks mentalization. Typical statements may be: ‘you are trying to drive me crazy’; ‘your grandma is in league with your father against us’; ‘you provoked me’; ‘you don’t care about whether your dad is here or not’; ‘you don’t care about me’; ‘you would be glad if I were dead’. Such statements inevitably generate further arousal that is incompatible with mentalization and can lead to nothing but further non-mentalizing cycles. Entering into a discussion about the meaning of such statements is almost guaranteed to fail, as these can only make sense in a non-mentalizing world. Therefore, a therapist who attempts to question the meaning of such statements inadvertently contributes to the non-mentalizing cycle and at best achieves pseudimentalization (discussed below). Non-mentalizing, by definition, cannot be interrogated in a mentalizing manner – one cannot reflect on the content of one’s own mindlessness. The discourse needs to be shifted from a non-mentalizing to a mentalizing one. This is perhaps most easily done by retracing one’s steps (rewinding) to where
mentalization was last evident. The family narrative can then begin again from that point.

**Psychic equivalence, pretend modes and the misuse of mentalization in families**

We have already talked about the subjective experience of children whose parents are temporarily or chronically unavailable and how this can generate a kind of circular or cyclic hopelessness. The consequence is a change in the quality of each person’s experience of his/her internal states and self-awareness. A person who is depressed may experience as entirely real her negative thoughts and feelings about herself. Because of an experience of other family members’ absence of interest in her state of mind, she may lose the perspective that would allow her to think differently about herself and others. In the absence of relational mentalizing strengths (such as curiosity, reflective contemplation and perspective taking), a pessimistic sense that feelings can never change may take over. A feeling of hopelessness is taken to be a physical reality the moment it is experienced. It cannot be treated as just a thought, which might be cognitively challenged. The term ‘psychic equivalence’ (Fonagy 1998) refers to a developmentally immature form of mentalizing in which mental states are experienced as having the same status as physical reality. As we know, this is a normal developmental stage for preschool children, whose fears cannot be assuaged by the reassurance that such fears are unfounded. It is a stance which, when found in adults, could be paraphrased thus: ‘everything in my mind is out there (that is, is real and true), and everything that is out there is also in my mind (that is, known to me)’.

Toddlers know everything there is to know and everything they know is true. Psychic equivalence can persist in children beyond toddlerhood if mentalizing is insufficiently supported in the family. It may momentarily return for adults when emotional arousal prevents genuine mentalizing. In such instances, one’s own thoughts and feelings override the capacity to critically reflect on the thoughts and feelings of anyone else. It is sufficient for someone to have the impression that another person’s action (for example, looking at her watch) is a clear indication that she is bored in his presence for that inevitably to mean that he is hopelessly boring and that this is the only interpretation possible of her behaviour. It is this momentary inability

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to entertain alternative explanations and perspectives that gives mental states in psychic equivalence such undue force.

In the state of psychic equivalence, often only what is observable in the physical world is experienced as significant (Fonagy et al., 2002). There are times when utterly concrete thinking can take over the whole family so that nothing except changes in physical circumstances (that is, observable outcomes) are felt to be sufficiently real to matter. Specific aspects of behaviour can acquire undue significance. For example, a focus on expressions of appreciation can take the place of cultivating and exchanging genuine gratitude: that a child say ‘please’ or ‘thank you’ becomes intensely important to an insistent parent, who neglects the child’s actual feelings.

The concept of psychic equivalence enables us to conceptualize the success of specific systemic techniques, such as concrete changes in the therapy room (for example, as described by Minuchin [1974], placing people on different chairs or closer to each other, or making them face each other). These techniques make non-mentalizing families accessible to therapeutic intervention through an alteration in the physical domain because this alteration has palpable consequences for the family’s subjective experiences. Reflecting on these consequences will inevitably induce (strengthen) mentalizing. This is the hidden benefit of creating new perspectives and ways of viewing the other.

In families with poor boundaries between the generations – these families are often referred to as enmeshed – certain types of intrusive mentalizing can take place. Here the separateness of minds is not respected and family members strongly believe they know what other individuals think and feel. The family discourse may indeed sound as if everyone is mentalizing well but, paradoxically, this does not have the usual consequence of people feeling understood. This form of interaction can be described as pseudo-mentalization. Pseudo-mentalization, too, has its developmental origins in toddlerhood, when children create imaginary mental worlds that they are able to sustain as long as these are not confronted by physical reality (Target and Fonagy, 1996).

When the adult continuation of this pretend mode grips a family, each family member will seem to be mentalizing but will in fact fail to connect with anyone else’s reality. The family members will therefore remain disconnected from each other. This experience may make them all redouble their efforts to have their interpretations accepted by everyone else. In doing so, more and more unfounded assumptions may be made about other people’s mental states. Family
members invest a lot of energy in thinking or talking about how everyone thinks or feels but these ruminations bear little or no relationship to actual states of mind. As a result, the attempt to mentalize may be experienced as obstructive and confusing. This can altogether block further mentalization efforts.

Another form of pseudo-mentalization is coercion of a person’s thoughts. For example, a man can undermine his partner’s capacity to think by deliberately humiliating her in a family gathering, disclosing something that she might have confided in private. These phenomena are most pernicious when they serve, in the context of abuse, to undermine the partner’s confidence in her self-awareness: ‘you enjoyed it when I touched you like that’. These experiences may undermine confidence in one’s subjective experience and lessen the extent to which mentalization is felt to be worthwhile. This is not simply because such statements directly contradict the victim’s own experience (‘you fell down the stairs; I never hit you’), but also because the victim may be unable to construct a bearable image of what thoughts must have been in her partner’s mind in order for him to make such confusing statements.

At the extreme end of the non-mentalizing spectrum is the misuse of mentalization. Here, the understanding of mental states of oneself and others is not directly impaired; rather, it is used to further a person’s self-interest at the expense of the well-being of the family or one of its members. One example may be how a child’s current mental state (for example, sadness) is used to provide ammunition in a parental battle (for example, ‘whenever you visit your father you feel so sad afterwards; don’t you think you should stop seeing him?’). The child’s feelings have been exaggerated or distorted by the parent for her own purposes. Because being understood occurs in the context of being manipulated into an undesirable position in relation to loved ones, the child in this situation may come to experience as adverse all the activities of mentalizing. Another example is a father who criticizes and complains to his wife that her taking a job means that the children feel neglected and rejected and that, as a result, they are evidently suffering. He may not be aware that his wife’s growing independence generates in him fears of abandonment.

A mentalization focus in systemic therapy

The therapists’ primary focus during this form of treatment is on the thoughts and feelings of each member of the family and on the
relationships between them. They acknowledge and positively connote different perspectives, and they repeatedly and explicitly check that they have properly understood what somebody means (‘let me just check that I’ve got this right’). The therapists show that they cannot know what a member of the family feels without asking a question to find out. They help individuals to communicate and express what they feel (for example, by stopping the conversation to ask ‘naive’ questions about what it is that the person feels they cannot say or explain). Therapists add a mentalizing element to linear or blaming statements by family members (such as, ‘he’s always trying to wind me up!’) by inquiring, for example, ‘and do you think that he is being deliberately annoying?’ The therapists may ask triadic mentalization-eliciting questions, for example by inviting one of the family members to say something about the relationship between two other people (‘how do you think your parents felt towards each other while you were shouting?’). ‘What if’ questions are also employed. A therapist might say to a child who had had a tantrum because he wanted his parents to stop the car: ‘What would you have felt like if she had stopped the car?’ To the mother, the therapist might say: ‘What did you think he would think and feel if you did stop?’ Though what if questions risk eliciting pseudo-mentalizing from family members in pretend mode, they can also be a useful tool for therapists confronted with the concreteness of psychic equivalence. Contemplating alternative perspectives can shift the family’s thinking towards a more mentalizing mode.

Mentalization-focused interventions move from orienting questions to the creation of an agreed language for talking about affect. The interpersonal and emotional contexts of important events are explored by reference to accompanying mental states. This can be quite laborious, as people often want to restate the sequence of events and ‘facts’. Mentalizing strengths are identified and highlighted throughout this process. Therapists themselves may serve as good models for mentalizing when they ask for clarification and reflection, using the sequence: ‘Stop, replay, explore and reflect’. This means pausing to think, reviewing what just happened, exploring feelings and beliefs and then reflecting on these. This is particularly useful for therapists when they are faced with stark examples of non-mentalization. Reviewing the process by which mentalization was impaired or lost is a key effective component of the approach. Unless therapists consciously stop to consider the feelings and thoughts at the moment before the loss of mentalization, the therapists may inadvertently feed into the proliferation of a non-mentalizing stance.
We have already stressed that mentalizing therapists take an inquiring and respectful stance in relation to other people’s mental states, conveying the notion that understanding other people’s thoughts and feelings is important. Therapists communicate this to the family as a whole and help individual family members to focus on what feelings are experienced by each person. They also highlight the ways in which miscommunication or misunderstanding (or lack of understanding) of these feelings leads to interactions that contribute to, or maintain, family problems. In practice, this requires that therapists strike a very careful balance between creating a therapeutic context that allows the family to interact naturally (including actively eliciting habitual and possibly problematic family interactions around difficult issues) and being directive and intervening at critical moments. Since the MBT-F approach postulates that non-mentalizing interactions are unlikely to produce significant changes in family interactions, merely allowing these interactions to occur is considered unlikely to be therapeutic. Therefore, once therapists have a clear idea of the core mentalizing problems and once they have appropriate examples of related interactions to work with, they can intervene (actively bring non-mentalizing interactions to a halt) and shift attention away from non-mentalizing processes. One major aim of MBT-F is to highlight for each family member perspectives he/she may be missing, and to point out how this leads to not fully noticing and understanding the behaviour of others.

We hope it is by now evident that the primary advantage of a focus on mentalizing is that it supports therapists when they find themselves caught in non-mentalizing interchanges within the family. One of the underlying assumptions of MBT-F is the belief that mentalizing is part of a self-righting gyroscopic function of family systems. In other words, MBT-F assumes that many problems in families will be reduced (if not fully addressed) if the abilities of family members’ to think about each others’ states of mind are promoted and freed from obstacles. The principal dangers for therapists lie in the contagious nature of non-mentalizing and in the temptation to engage with non-mentalizing, physical reality-oriented interactions when faced with the challenge of contemplating the destructive and negative thoughts and feelings that can exist but remain (for good reasons) ignored within family systems. Taking a mentalizing approach is not a panacea that will eradicate impossible family conflicts. Simply drawing the family’s attention to putative sources of hostility in the family (a classically psychoanalytic interpretative approach) is unlikely to be
successful, as non-mentalizing precludes the genuine contemplation of alternative ideas.

An emphasis on mentalization does not radically alter the priorities of a systemic therapist but it focuses on phenomena that might otherwise be marginalized. It can enhance the effectiveness of systemic therapy by providing a way to get around common blocks in therapy and by making family members more receptive to tuning into each others’ thoughts and feeling-states. The therapist aims to help the family members hold on to mentalization in the face of challenges to thinking and to contemplating feelings, challenges that previously they have not been able to overcome. In the light of the systemic investments that may be marshalled against this aim, it is, in our view, essential that the therapist has a structure to support a mentalizing focus. This framework is described in the next section.

The mentalizing loop

The mentalizing loop is a technique that provides a pragmatic framework for devising mentalization-based interventions and connecting the therapist’s observations of family interaction with the family members’ underlying feeling states and related thoughts. It is a tool for change, with five different mentalizing positions that the therapist takes: punctuating, checking, mentalizing the moment, generalizing and reviewing. It allows therapists to structure sessions and can serve as a route map that can be followed. We talk about it as a loop since it is not a linear progression of successive steps but a recursive process of observing, checking, reviewing and making new observations. This leads to further mentalizing, checking and observations – and so on.

As a first position, during any stage of any session, the therapist makes a tentative statement (punctuating) about an interaction between family members that she has observed in the here and now of the session; for example, ‘I notice that whenever dad talks, Johnny [the son] looks anxiously at mum. Has anybody else here noticed this, or am I just imagining it?’ Immediately checking this observation with family members (‘has anyone else noticed this?’), which is a highly specific and deliberate punctuation of an otherwise complex interaction sequence, is very important in ascertaining whether what the therapist has observed resonates with the family members. In this example the therapist first identifies and highlights an interaction that (to her) appears to be related to some mentalization difficulty. She
then checks her observation by inviting the family and its individual members to connect with it, but also giving them the chance to dismiss it. It is possible that some or all family members might, for example, state that they have no idea what the therapist is going on about. This should then lead the therapist both to reflect on the validity of her punctuation in the light of the feedback and to consider the possibility (and reasons) that family members are protecting themselves from the implications of the therapist’s observation.

If there is some acknowledgement between family members and they engage with the therapist’s observation, then the important position of mentalizing the moment can be taken. The therapist models a mentalizing stance, showing respect for and curiosity about the minds of others. This attitude conveys the notion that learning about how others are thinking and feeling is enlightening:

What do you think this is about? What do you imagine is Johnny feeling that makes him behave like this? And how does this affect others? Dad, what do you make of it? Maybe I got it all wrong – what do you think, Mrs Jones? I wonder, Dad, what it feels like for you when Johnny looks at mum in this way? What do you think it feels like for Johnny? If one could see thought bubbles come out of your wife’s head, what might be in there about how she thinks Sally feels right now?

This invitation to undertake some form of emotional brainstorming encourages family members to voice feelings. The therapist then facilitates discussions between the family members (rather than merely leaving the action to take place between the therapist and individual members of the family): ‘Let me see if I got this right – are you saying that when your dad talks like that it makes you feel a bit lost and you look at Mum because she is worried? Do you think she is – or does anyone here have a different view? Can you all discuss this with each other?’

In order to encourage mentalizing by each member of the family, a whole range of different mentalizing techniques can be employed (Asen and Fonagy, 2011; Fearon et al., 2006). Overall it is the therapist’s task to slow down the interactions between family members, questioning or expressing a specific interest in exactly what each person is feeling as this interaction unfolds. The aim is to temporarily pause the flow of exchanges between family members and permit further reflections all around. At some stage the therapist will attempt to help family members to generalize, moving away from discussing the specific interaction and widening their view. Family members are invited to come up with some more general observations and reflec-
tions on how similar interactional patterns tend to evolve spontaneously at home and what feeling states these elicit:

So we saw that when dad talks, mum feels anxious and Johnny picks this up. Maybe this is the only time it ever happened, but maybe it is not. Can you talk together about whether you recognize this as something that happens at home or elsewhere?

In an attempt to identify and address typical problem situations, what has been observed in the here and now of the session is looped out into real life situations. This leads to family discussions of problem-relevant situations. The focus remains on eliciting and highlighting emerging feeling states and how these express themselves in behaviour. The therapist actively encourages family members to label their own feelings, to reflect on what that must be like for them: 'you may want to find out how feeling leads to doing/how a few snowflakes can launch an avalanche/how a little feeling can get out of control'.

At a later stage, often towards the end of a session, the therapist will want to review what this experience has been like for everyone. Here one looks back and checks the feeling states of each individual family member. This helps both therapist and family to evaluate how a new and emotionally charged experience has registered with the different individuals and it provides an opportunity to reflect together on what happened and its possible consequences:

What did you make of what happened? Can you talk together about what this was like for each and all of you? Are there any conclusions you can draw from this?

To follow this mentalizing loop rigorously, or even rigidly, would be a rather non-mentalizing, possibly even mindless enterprise. We have included it here as a model of what is necessary to create and maintain a focus on mentalizing, as mentalizing can be quite slippery. One aspect this article aims to highlight is that while in therapy there needs to be a deliberate, conscious and consistent focus on mentalizing, this cannot become a routine or be programmed. Almost everybody can mentalize, but the occasional piece of mentalizing will not be sufficient when we undertake therapeutic work. It is a difficult task to find a balanced way of mentalizing and every therapist needs to find his/her own frame for it. There can be no prescription for the right amount of mentalizing, as mentalizing refers to a mental attitude rather than a dose of medicine to be dished out at regular intervals. Caring for one’s mind is at least as complex a task as caring for one’s body, though there

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is no equivalent for the adage ‘an apple a day keeps the doctor away’. To take on board the full implications of using a mentalizing approach is a considerable task – for both therapists and families. Therapists have to respect the courage and commitment of families when they adopt this way of working. Non-mentalizing is not all that difficult and, on occasion, it is perhaps desirable. It can, however, be very harmful in the long run. Mentalizing, on the other hand, is immediately risky and can be demanding and exhausting. It requires us to give up the illusion of certainty that comes with believing we know.

Summary of the mentalizing approach to family therapy

In summary, there are four characteristic features of the stance adopted by the MBT-F therapist: (i) an inquisitiveness that constantly affirms the value of mentalization by a respectful, curious and tentative attitude; (ii) maintenance of a balance between observing natural interactions and intervening to promote change by helping the family make sense of the feelings that are experienced by each family member and highlighting ways in which miscommunication or misunderstanding (or lack of understanding) of these feelings leads to interactions that maintain family problems; (iii) interventions that terminate non-mentalizing interactions and help create new and different perspectives by highlighting for each person missing points of view (points of view without which they cannot fully understand the behaviour of others); and (iv) the highlighting and reinforcing of positive mentalizing, thus deepening people’s ability to connect feelings, thoughts and intentions – that is, positively connoting good examples (or episodes) of mentalization and possibly enlarging on their implications.

Once a problematic interaction comes into focus, the family is invited to find ways to describe it. The therapist uses pause and review techniques to help the family collaborate (form a working party) in thinking about their interactions from the perspective of a higher order. The focus on the mental states that might underpin a specific interaction serves the dual function of provoking the family members’ curiosity about one another and of generating the attitude that learning about how others are thinking and feeling is potentially enlightening. Gradually, the family discourse is expected to shift away from discussing a specific interaction that occurred during the session in order to capture more generalized understandings. As part of this process, the therapist may ask the family to consider alternative interaction strategies. This generates possible applications of the
specific understandings gained. The therapist may then help the family to plan the implementation of suggested changes. Reflecting on the process of engaging in a mentalizing approach is key to sustaining the process. Even if the meta-reflection seems to produce negative results, it can provide the basis for understanding the next episode of non-mentalizing (that is, for trying to understand what might have gone wrong with the process of trying to understand each other that has just been unsuccessfully undertaken).

The *MBT-F Manual* (Tiddly Manuals, 2010) includes a number of mentalizing activities. These are presented as games or tasks that the family can undertake. The therapist can choose from these in order to overcome specific barriers encountered in the treatment. These tasks mainly function as ice-breakers; they create a gradual acclimatization to mentalizing in families in which past experiences have created an implicit concern or even a phobic avoidance of the activity. The tasks also have a skill-developing function, as well as the potential to generate relevant information (alternative perspectives) when the family appears to be stuck on a specific issue. The tasks can also help with the generalization of learning as part of homework (tasks the family can practice without the therapist). An example of a mentalizing task involves the inversion of roles. The child or adolescent is asked to identify a situation they find complex or conflict-ridden and the parents are asked to adopt the child’s persona in that situation (for example, going to a school function, doing chores or going to bed). In role-playing the child, the parent has to imagine and report on what may be going on in the child’s mind during the scenario, while the child just listens to the parents struggling with the task. Then the child is encouraged to help the parents out or counsel them by telling them what to think, say and feel. At some point the therapist encourages the parents and child(ren) to reflect on how they think or feel in ways that are both similar to and different from what has been played out.

In the feeling-finder game, family members are invited to create a story centred on experiencing feelings. At each significant moment in the story the person telling the story says ‘and that made me feel . . .?’ The child then has to find the facial expression or emotion word (as appropriate to the child’s developmental level) that they think fits the situation. The person telling the story then tells the child what he or she actually felt. Each time the child gives the same answer as the storyteller, the child moves one space on a snakes-and-ladders type board. When the child does not give the same answer as the story-
teller, the family or therapist help the child understand what the situation meant to the protagonist and what he/she thought.

In the thought–pause button activity, the family identifies a problem scenario and the therapist asks them to re-enact it. Just before the child performs the problematic action, the child presses the pause button. With the pause button on, one member of the family takes the child’s place and the child walks away to stop and think. The child tries to come up with as many reasons as he/she can why he/she shouldn’t do the action. Every few moments, the parent says, ‘I’m going to do it’ and the child has to say, ‘No, stop and think’, and continues to brainstorm reasons. Finally, the child tells the parent all the reasons he/she came up with and the parent praises him/her. This can highlight how mentalization can be maximized when stressful or difficult situations are slowed down. In the brain scanning game each family member is given a diagram of a cross-section of an adapted human brain containing more than 10 larger and smaller ventricles (holes). Father is told, for example: ‘Imagine this is your daughter’s brain or mind. Put in the holes all the thoughts and feelings you think she has at the moment. Put the big feelings and thoughts in the big ventricles and the smaller or secret ones in the smaller holes.’ The mother can be given the same task – and the daughter could be asked to imagine how her mother might see her mind-brain. When everyone has completed the task (in 5 minutes), the three different ‘brain scans’ can be displayed and compared. This can be followed by a discussion of how each family member can seemingly accurately read the mental states of the others, but also of the fact that one can never fully know what other people think or feel.

Whether observing normal interaction or playing mentalizing games, at the core of this therapeutic approach lies the same deep commitment to help the family make sense of what feelings are experienced by each family member, what thoughts are connected with these feelings, how these feelings are communicated within the family and how miscommunication or misunderstanding (or a lack of understanding) of these feelings can fuel interactions that maintain family problems.

**Preliminary conclusions**

Work with emotions in the context of family therapy is gaining pace, though it is often not a priority and is usually linked with psychoanalytic practices (Pocock, 2009). The idea that a person’s emotions are deeply influenced by the prevailing emotional system she finds herself part of at any given moment (Bertrando and Arcelloni, 2009)
is perhaps not a novel one; but the emphasis on working with emotions in the here and now is still fairly recent in the systemic field (see, for example, Dallos, 2006; Fredman, 2004; Kavner and McNab, 2005; Pocock, 2005). Various systemic practitioners have explored the therapeutic territory that transcends the seemingly clear distinctions between systemic, psychoanalytic and cognitive approaches and have helpfully discussed the common ground (Donovan, 2009; Flaskas, 2009; Larner, 2000). Do we need a new therapeutic approach? MBT-F has some distinctive features that are different from, but complementary to, the systemic approach. It is different from, but also has plenty in common with, other more recently emerging family therapy approaches that emphasize the importance of attachment theory (Akister and Reibstein, 2004; Byng-Hall, 1991; Dallos, 2006; Diamond and Siqueland, 1998) or that attempt to bridge the systemic and psychodynamic worlds (Flaskas, 2002; Fraenkel and Pinsof, 2001). An emphasis on mentalization does not radically alter the priorities of a systemic therapist but it focuses on essential phenomena that might otherwise be marginalized. It can enhance the effectiveness of systemic therapy by providing a way to get around common blocks in therapy and by making family members more receptive to tuning into each others' thought and feeling states. Above, we have outlined some of the positions and strategies therapists can adopt when using mentalizing in family therapy. The approach is not considered by any of us to be a new form of therapy. If anything, it takes systemic approaches back to what is probably a core and common aspect of all psychotherapeutic work: the elaboration of subjective experience to facilitate interpersonal understanding. More specifically, at this time MBT-F perhaps provides an approach that bridges the often seemingly opposing internal psychodynamic and external systemic worlds. It does so by integrating important concepts from the fields of attachment theory and reflective function (Fonagy et al., 1991) with systemic approaches, and in this way MBT-F is itself an example of what good mentalization can achieve in resolving apparently irreconcilable points of view.

References


