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Mentalizing as a Compass for Treatment

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This article is based on a patient education program the authors are conducting in the Professionals in Crisis program at The Menninger Clinic. This program is designed to foster a therapeutic alliance by helping patients understand a central aim of treatment, namely, fostering mentalizing, the awareness of mental states in self and others. The educational material is based on research in the Menninger Child and Family Program. The educational sessions are conducted like seminars in which the leaders and patients collaborate in understanding these concepts and their application to treatment. Patients in the program are provided with this article as background material for the seminar.

Many persons with serious psychiatric disorders require intensive treatment. Medication or individual psychotherapy alone—or even their combination—won't always do. Patients who have not benefited sufficiently from less intensive outpatient treatment may require inpatient treatment that provides for comprehensive assessment and combines a wide range of interventions—not just medication and individual psychotherapy, but also group therapy, family work, educational groups, therapeutic activities and a specialized milieu. Crucial to such treatment is a social environment that provides support, a feeling of belonging and ample formal and informal opportunities to confide in peers and learn from them.

Such a rich array of therapeutic interventions confronts us with a problem: How does it all work? It is no small challenge to understand how medications work or to understand how individual psychotherapy helps. Researchers have been studying these interventions for decades. When we combine these standard interventions with many other therapies, understanding the basis of our treatment's effectiveness becomes even more challenging. We all subscribe to the "bio-psycho-social" model of treatment, believing that we must integrate the biological, psychological and social domains, as well as the spiritual domain. But this is a vast territory to cover.

If we mental health professionals must struggle to understand how our complex treatment works, and we've devoted our whole professional careers to it, how much harder must it be for patients to understand what we're doing and why? As one of our mentors, psychologist Irwin Rosen used to say, we need a compass for treatment. A compass is not enough to get you anywhere, and no single concept could begin to explain how all of treatment works. But we need a general direction. Working with our colleague, British psychologist Peter Fonagy, we have identified a concept that provides a sound orientation to treatment: *mentalizing*. We believe that helping patients understand how we are thinking about treatment—our conceptual compass—will help them make the best use of it.

Educating patients about our understanding of treatment can make an important contribution to establishing a therapeutic alliance, and we know from extensive experience and research that a therapeutic alliance is crucial to a positive treatment outcome. The therapeutic alliance entails active collaboration between patients and their treaters, and such collaboration is based on a sense of working together toward shared goals. This collaboration requires shared understanding, and the concept of mentalizing provides a focal point.

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I. Understanding Mentalizing

Mentalizing refers to the spontaneous sense we have of ourselves and others as persons whose actions are based on mental states: desires, needs, feelings, reasons, beliefs and the like. Normally, when we interact with others, we automatically go beneath the surface, basing our responses on a sense of what underlies the other person's behavior, namely, an active mind

and a wealth of mental experience. Thus we are natural mind readers, and mentalizing entails accurate and effective mind reading. By virtue of being human, this process of mentalizing comes so naturally to us that we easily overlook its significance. To understand psychiatric treatment; however, we must pay careful attention to mentalizing and the conditions under which this basic human capacity becomes impaired.

We mentalize in relationships with other persons, not in interactions with inanimate objects. A brick is a static object, inert and unresponsive, always behaving in the same way. A person's behavior is based on mental states that are always in dynamic flux, which makes understanding other persons (and ourselves) the most complex problem solving of which we are capable. Evolutionary biologists now argue that the reason we developed such fancy brains is the sheer complexity of making sense of each other for the sake of our cooperative—and competitive—living.

Mentalizing Explicitly & Implicitly

Sometimes we mentalize consciously. When we are puzzled about another person's actions, we may wonder, "Why was he so abrupt with me? Is he irritated because I didn't return his call right away?" And we mentalize consciously when we are puzzled by our own actions—"How could I have binged on that ice cream when I was so resolved to stick with my diet?"

The majority of our social conversations revolve around gossip, in the benign sense that we mostly talk about ourselves and others—what we are doing and why, and what they are doing and why. Mainly, we seemed to be interested in making sense of our social world and our place in it. We are busy practicing mentalizing.

But thinking and talking about what is going on in our own mind and the minds of others is only part of our mentalizing activity, perhaps just the tip of the iceberg. When we interact with others, we mentalize intuitively, just as we ride a bicycle by habit. Thus we don't just mentalize at an intellectual level; we mentalize at a gut level. When interactions go smoothly, we need not think explicitly about states of mind—our own or the other person's. We can respond automatically, mentalizing implicitly. For example, we often respond to others' emotions without thinking about it, nodding sympathetically with a concerned look on our face as we listen to a friend talking about her child's frightening accident. Another example: we naturally take turns in conversation, being sensitive to pauses and unthinkingly keeping our conversational partner's point of view in mind.

Mentalizing & Mental Health

Mentalizing is crucial to our well-being in several respects. First, mentalizing implicitly and explicitly is the basis of self-awareness and a sense of identity. Importantly, when we mentalize, we have a feeling of *self-agency*, being in control of our own behavior. Thus mentalizing provides us with a spontaneous sense of ownership and responsibility for our actions and our choices, rather than feeling that our behavior just "happens."

Mentalizing allows us to have an intuitive, as well as an explicit, sense of ourselves that has coherence and continuity. When all is well, we have a spontaneous sense that our different roles, attitudes, states of mind and modes of experiencing fit together coherently, like the pieces of a puzzle. We maintain a sense of continuity throughout different patterns of relating—as serious professionals, concerned parents and playful participants in friendly banter. We maintain a sense of continuity throughout different emotional states—feeling angry, elated, anxious, triumphant and vulnerable. These various experiences form a whole—a self—that we feel and believe is "me."

Second, mentalizing is the basis of meaningful, sustaining relationships. When we mentalize spontaneously, we cannot help but empathize, that is, putting ourselves in the other person's shoes and seeing things from their perspective. While empathizing, we retain self-awareness, a sense of where we are coming from. Such intuitive empathizing—with ourselves and with others—is the cornerstone of healthy relationships and ordinary human interactions. It makes possible the moment-to-moment adjustments we make effortlessly to the verbal and

emotional signals we read in other people's behavior. For example, when we sense boredom, frustration or approval, we adjust our own behavior accordingly to convey our perspective and sustain the give-and-take that defines reciprocal human exchanges. Under ordinary conditions of mentalizing, we make these adjustments without much conscious reflection.

At their most fulfilling, relationships involve a meeting of minds. We feel affirmed and validated when we sense that the other person has our mind in their mind. We are not alone. We not only feel heard and understood, we *feel felt*. We connect through reciprocal mentalizing, when we are thinking explicitly about each other or, more often, when we are interacting intuitively, by feel.

Third, mentalizing is the key to self-regulation and self-direction. Mentalizing allows us to develop a sense of self that includes a sense of coherence, continuity and responsibility for our choices and behavior. At the same time, mentalizing makes possible our engagement in reciprocal, sustaining relationships. By integrating a sense of self and a sense of connections with others, mentalizing enables us to manage losses and trauma, as well as distressing feelings such as frustration, anger, sadness, anxiety, shame and guilt. Mentalizing, we manage these feelings *without* resorting to automatic fight-or-flight responses or efforts to cope that are ultimately self-destructive or maladaptive. Instead, coping and self-regulating responses based on mentalizing preserve flexibility and choice. They give us the tools to set goals for ourselves, to define the steps we need to take to achieve our goals and to imagine ourselves as the person we want to *become*. From these capacities we generate the two most basic protective experiences human beings can produce: *meaning* and *hope*.

Our focus on mentalizing in psychiatric treatment is based on a growing body of evidence that points to mentalizing as the key to resilience—the ability to adapt successfully to adversity, challenges and stress. By promoting resilience, mentalizing facilitates coping with vulnerabilities, including the genetic vulnerability to psychiatric disorders such as depression, bipolar disorder, anxiety disorders and addictive disorders. Research is demonstrating, for example, that persons who can mentalize in the face of trauma—including childhood trauma—are less vulnerable to psychiatric disorders. Research is also demonstrating that adjustment and quality of life of people with various psychiatric disorders is ultimately determined by abilities that result from mentalizing.

Here are some of the abilities that mentalizing promotes:

- the capacity to *make meaning* of adversity;
- the capacity to sustain a positive outlook with *hope, initiative* and *acceptance*;
- the capacity to experience the *mastery* derived from feeling *responsible* for our own behavior;
- the capacity to have a sense of *purpose* and engage in healing and inspiring rituals based on *shared values*;
- the capacity to *communicate* and *solve problems* by seeking clarity and speaking the truth;
- the capacity for *flexibility* and *humor*;
- the capacity to feel *connected* and to give and receive *support*;
- the capacity for open *emotional expression* and *sharing* of a full range of feelings and
- the capacity for *mutual empathy* which allows us to see both our own and the other person's perspective.

Mentalizing & Flexibility

As we will discuss shortly, failure to mentalize in relationships may leave one stuck in rigid, repetitive patterns of interaction. Conversely, mentalizing actively affords flexibility and choice, yielding options rather than being confined to automatic stimulus-response patterns. For example, when we mentalize, we are able to consider another's behavior—and our own—from multiple perspectives. Even a four-year-old can be capable of mentalizing in this way. Sensing his mother's irritation, he might think he's to blame. Mentalizing, he also can consider other possibilities: she's frustrated with his sister or with her own inability to find her car keys. He's not confined to blaming himself for all her distress and feeling guilty in the process.

Flexibility may be the key to how we know when we're mentalizing. The hallmark of mentalizing is seeing oneself and others from a fresh perspective, with an inquisitive and open-minded attitude. Making rigid and untested assumptions and projecting our own feelings and needs onto others interferes with mentalizing. Thus mentalizing entails seeing oneself and others realistically. British philosopher and novelist Iris Murdoch, made endearingly famous in the film, "Iris," captured the challenge: "The difficulty is to keep the attention fixed upon the real situation."

Mentalizing is also evident in humor and play. Humor always involves a shift in perspective, for example, the capacity to laugh at one's foibles. And telling a joke well requires mentalizing, gauging the other person's understanding and reaction, and timing the punch line just right. Humor is one form of play, and play is a step toward mentalizing, taking an "as if" attitude toward reality. The capacity to play with ideas, to imagine what might be on another person's mind or in another person's heart (or one's own) is prototypical of mentalizing.

In sum, by mentalizing we see human reality for what it is. To see reality rightly, we must be able to play with imagination and alternatives, actively testing out our perceptions rather than operating on fixed assumptions. Fresh perspectives replace stale habits. A plain example: when you fear your friend misinterpreted what you said or did, you can check it out.

It is important to appreciate that, while our brain is designed for mentalizing, it is also designed to turn off mentalizing in response to danger. Research into neurophysiology is showing that the activation of the fight-or-flight system—a brain system that activates the psychological and neurohormonal responses triggered by signals of danger—also leads to the *inhibition* of mentalizing.

Evolution has prepared us to fight or flee when our survival is in danger; we respond in a fairly automatic, procedural way, unencumbered by reflection or empathy. In fact, it appears likely that we human beings are capable of violent or destructive acts against one another only when we go into the fight-or-flight mode and momentarily stop mentalizing. Psychiatric disorders reflect maladjustment associated with the *persistent inhibition of mentalizing*. Such inhibition may be triggered by internal states or interpersonal situations—such as feeling close and dependent. The inhibition of mentalizing leads to inappropriate responses that impair our interpersonal relationships and perpetuate maladaptive cycles of experience and coping.

How We Learn to Mentalize

Given its importance, we must give high priority to understanding the conditions under which mentalizing flourishes. Fortunately, we have a strong head start, because considerable research has been devoted to understanding how mentalizing develops, as well as the developmental factors that interfere with mentalizing. We aim to use what we have learned about the development of mentalizing to guide our treatment efforts.

The single most important factor in fostering mentalizing is a secure attachment relationship—a close emotional bond. An infant who confidently reaches out to an attachment figure for comforting in times of distress displays secure attachment in its prototypical form. The secure attachment figure—a mother, father or other caregiver—provides a *safe haven*. Contact with the attachment figure yields a feeling of security.

But there is another aspect to secure attachment that is every bit as important for development: the *secure base*. Having confidence that the attachment figure can be relied upon if needed, the securely attached infant eagerly explores the world. For decades, attachment researchers have observed securely attached infants in a playroom with their mother, happily exploring all sorts of toys. More recently, we have come to appreciate that secure attachment does not just foster exploration of the outer world; it also fosters *exploration of the inner world*, the world of the mind, the mind of the self and the mind of other persons.

Thanks to attachment research, we now have a view of development that seems utterly backwards from what our intuition would suggest. That is, based on our adult mind, we might think that we first become aware of our own mind, and then we come to realize that other persons are similar—they also have a mind like ours. This incorrect intuition about development is based on our experience of empathizing with others: we actively imagine ourselves in their shoes. But developmental research shows that we learn about our own mind from the outside in: it is through the mind of another person—ideally a secure attachment figure—that we become fully aware of our own mental states.

The clearest example of this seemingly backward developmental progression is learning about our emotions. We know that the sensitive caregiver is attuned to her infant's emotions. She mirrors these emotions in her face and her tone of voice. Seeing her infant's distress, she shows a mixture of distress and concern on her face—she is mentalizing intuitively. Seeing her infant's frustration, she may screw up her face in an expression of mock frustration, showing her infant that she knows how he feels. The infant sees his distress or frustration on his mother's face; he feels felt. And two things happen. First, feeling felt, he finds his mother's empathic response to be comforting. Second, he begins to understand his own feelings. He sees how he feels in the face of his mother. She has his mind in mind. He discovers his mind in her mind.

Our colleague, Hungarian psychologist George Gergely, characterizes this process of emotional learning as *social biofeedback*. In standard biofeedback, we hook ourselves up to a measuring device that provides information about our physiological state. A finger thermometer, for example, measures the blood flow to the periphery of the body. When we are frightened, the blood flow goes to the heart and internal organs. We are ready for fight or flight, and our hands get cold. When we are relaxed, the blood flows more evenly throughout the body, and our hands warm up. In the thermometer, we can gauge our state of relaxation, which may not be so evident to us from the inside. Similarly, other persons provide social biofeedback: through their facial expressions and other responses, we can see outside what we feel inside. As in standard biofeedback, we get in touch with our feelings in the process of making the link between our internal states and the information we get from the outer world—other persons who are mentalizing.

Thus we learn to mentalize by being mentalized in secure attachment relationships. Two aspects of attachment security work together in this regard. First, we feel safe and calm, eager to explore. Second, we feel connected, open to seeing our mind in the mind of the other. And, just as secure attachment can foster mentalizing, insecure attachment can inhibit mentalizing. Imagine the child who finds contact with his attachment figure to be frightening. He will turn away from the mind of the attachment figure, feeling frightened rather than calm. He will not be inclined to explore the mind of the attachment figure, and he will be deprived of the opportunity to learn about his feelings through the eyes of another person. Similarly, his internal experience may be distressing, and he may learn to avoid self-awareness as well.

Of course, we have many opportunities to learn about the mind—our own mind and the minds of others—in early development. We learn about minds, not just through our primary attachment relationships, but also through all our other relationships as well. Children learn about minds from their parents, siblings, extended family members and peers. This learning continues throughout life. We all continue to need social biofeedback, not only to affirm what we feel, but also to recognize our emotions when we are out of touch with our feelings. Just as we do when we are infants, we will learn best about our own mind and the minds of others when we feel safe in a secure attachment relationship.

Perhaps the most common form of mentalizing in therapeutic interactions is identifying and labeling feelings. Peter Fonagy and his colleagues introduced the concept of "mentalized affectivity" to refer to a skill we all need: the ability to *mentalize emotionally*, that is, to *feel and think about feeling* at the same time. Of course, this ability requires comfort and familiarity with our emotions. Thinking about our feelings while we are feeling them is essential to regulating and controlling our emotional states effectively, rather than doing something impulsively to shut off the emotions. Ideally, we learn to identify our emotional states and

their various combinations (for example, feeling frightened of our anger); we learn to control their intensity and duration (either increasing or decreasing them) and we learn to express our feelings effectively to others and to ourselves. This is a tall order, and these are skills we develop and refine over a lifetime—not without help.

II. Mentalizing & Mental Illness

Mentalizing is basic to our human nature, but we cannot always take it for granted. For example, owing to a failure of brain development, persons with autism do not develop the normal capacity to mentalize. Many autistic persons, because of their failure to connect with the minds of others, do not learn language. Even those with autism who are able to learn language may find other persons' actions baffling. They remain out of step to a great degree. They lack the intuitive understanding of others that naturally guides social interactions.

The vast majority of us who are spared the ravages of autism develop the ability to mentalize—to understand ourselves and others both intuitively and through deliberate reasoning when we must sort out some confusing incident. Short of autism, our human brains are primed to develop these mentalizing capacities. Mentalizing is a skill and, like other skills such as athletic or musical ability, there are wide individual differences. As with other skills, the interplay of genetic makeup and environmental support will determine an individual's level of ability. In particular, the development of this natural mentalizing capacity must be nourished and maintained by close and trusting human relationships—secure attachments.

Problems in relationships often contribute substantially to psychiatric disorders, and problems in mentalizing—interpreting our own behavior and the behavior of others—play a large role in this contribution. Although most of us develop considerable mentalizing capacity, we may not be able to use it freely or fully. At bottom, all psychiatric disorders involve persistent or intermittent *misinterpretations* that give rise to rigid, automatic and maladaptive patterns of coping, feeling and behaving.

Substance Abuse

Substance abuse is a clear example of failure to mentalize. At the extreme, addicted persons can be so preoccupied with obtaining the substance and getting high that they are oblivious to the impact of their actions on their own life or their relationships. They are flying blind. In this instance, the erosion of mentalizing can be an unwitting consequence of substance abuse. Of course, substances also can be used intentionally to avoid mentalizing, that is, as a deliberate effort to obliterate painful mental states.

Short of extreme addiction, however, we all struggle with impulses that are difficult to control—or perhaps we fail to struggle enough. A person in the throes of alcohol abuse may binge whenever he feels angry or resentful. A frustrating interaction with his boss generates the impulse to drink, and he goes from impulse to action, bypassing thought about what he is feeling and its relation to what he is doing. He may just feel an urge to drink, only dimly aware of the anger that evoked it. Unaware of his chronic problem with self-restraint, he may rationalize: "I'll have just one." Without self-awareness, there is little possibility of self-control.

To their frustration, others who are close to the alcoholic may understand him better than he understands himself. And they are also likely to be frustrated with his lack of attunement to the impact of his behavior on them. In this instance, the failure to mentalize applies to both self and others.

Depression

Depression also erodes the ability to mentalize. Everything goes gray—or black. Captured by the depressed mood, the depressed person may lose sight of the impact of the depression on her thinking. She makes a mistake at work and thinks, "I'm a complete failure. I never do anything right. I'm worthless. What's the point in living?" She cannot see past her depressed state, and she may not be able to remember times when she was not depressed. Her depression seems never-ending. She cannot appreciate that her extremely negative thinking is a reflection of her current state of mind. She does not question her beliefs, but rather

considers them to be the absolute truth. If she were able to mentalize, she could appreciate that her thoughts are based on her mood: "I'm depressed and that's why everything seems so black today."

Depression also interferes with a person's capacity to mentalize in relationships. The depressed person, like anyone else who is ill and suffering, is likely to be self-preoccupied and disengaged. It takes energy and interest to interact and to be aware of others' needs, feelings and desires. We all desire to be mentalized by others with whom we are interacting. We want others to be aware of us: it's painful to feel invisible. Thus the depressed person's sense of isolation may be fueled by others' tendencies to withdraw.

It is important to interrupt this cycle because, being unable to mentalize on her own, the depressed person needs the help of others. Other persons can see past her depression and help her to see past it as well. They can remind her, for example, that she has pulled out of depression before and can do so again. They can see what she cannot: she is in a depressed mental state, and that state can change.

Trauma

Symptoms of posttraumatic stress disorder also illustrate the failure of mentalizing. Posttraumatic stress disorder seems a particularly cruel illness in the sense that the core symptom is reliving the trauma, for example, in the form of flashbacks or nightmares. Owing to the illness, the person not only has suffered through the experience of extremely stressful events, but also, perhaps long afterwards, continues to reexperience these events in his mind. Reliving the trauma, it seems as if the memories—mental events—are real. Hearing the backfire, the Vietnam veteran literally dives for cover. Failing to mentalize, he has lost sight of the distinction between memory and current reality. Like the depressed person, he may need the help of others to mentalize—to become aware that he is safe in the present and that he is experiencing a posttraumatic flashback.

We all should be able to identify with the plight of the traumatized person. Just recall what it's like to wake up after a nightmare: mentalizing again, we think gratefully, "It was just a dream."

Trauma, and posttraumatic stress disorder in particular, is the most glaring example of problems with extreme emotional arousal—*hyperarousal* to put it technically. Like other mammals, we evolved to respond to threat and danger with the fight-flight-freeze response. This automatic reflex is adaptive: those who deliberated in the face of a charging tiger did not survive to pass on their genes. When physically threatened, you may need to run, not mentalize.

High levels of arousal tend to turn off the part of the brain that enables us to mentalize, the frontal cortex. Mentalizing and high arousal are in a reciprocal relationship: activating either one tends to deactivate the other. Persons who have a history of trauma may be quick to switch off mentalizing when their arousal increases. Learning to mentalize emotionally in the face of anxiety—if not a charging tiger—can help with emotional control.

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Personality Disorders

Problems in mentalizing also are prominent in a broad category of psychiatric disorders termed *personality disorders*. We must approach the topic of personality disorders with great care, because this can be a pejorative label: being told you have a personality disorder can feel like being told you are a bad person. We need an understanding of personality disorders that is helpfully illuminating rather than condemning.

Although we tend to think of personality as a characteristic of the individual, personality characteristics come to light in interpersonal interactions. Most of us can identify personality characteristics that disrupt our relationships—easy irritability, needing too much reassurance,

insensitivity, aloofness and so forth. Personality disorders involve a *persistent* and *recurrent* pattern of problems in interpersonal relationships along with maladaptive patterns of thinking, feeling and coping. Hence, personality disorders reflect rigidity, and smooth interpersonal relationships require flexibility.

Exemplifying the problem of rigidity, many personality disorders involve exaggerations of normal personality traits. Examples include being unrealistically suspicious and distrusting (paranoid), highly fearful of rejection (avoidant), excessively dependent on others for reassurance and guidance (dependent) or extremely self-absorbed and feeling entitled to special treatment (narcissistic). Borderline personality disorder does not correspond to any single trait, but involves emotionally intense and unstable relationships, often fueled by an intense fear of abandonment. Persons with borderline disorder also may show black-and-white thinking, evident in dramatic shifts in their perceptions of self and others, switching from all-good (idealized) to all-bad (devalued).

Mentalizing is essential to harmonious relationships, and problems in mentalizing play a significant role in personality disorders, which entail recurrent patterns of problems in relationships. Stable and fulfilling relationships require a balance of autonomy and connection, as well as give and take. These relationships depend on a combination of self-awareness and awareness of other persons.

A particularly important facet of personality disorders is a failure to appreciate the impact of one's actions on other persons, which depends on a combination of self-awareness and awareness of others. At worst, this involves treating others as objects rather than persons. Indeed, we believe that turning off mentalizing is crucial to mistreating others; conversely, mentalizing fosters compassion. To quote Iris Murdoch again: "The more the separateness and differentness of other people is realized, and the fact seen that another man has needs and wishes as demanding as one's own, the harder it becomes to treat a person as a thing."

In many situations, gifted mentalizers will be highly successful in love and work, because both depend so much on interpersonal skill. Ironically, gifted mentalizers may also be at risk for psychiatric disorders. For example, mentalizing can be a burden when hypersensitivity to how you are seen by others leads to self-consciousness, anxiety and shyness. A particularly problematic combination is this: genetic vulnerability to psychiatric disorders coupled with less than optimal environmental support. Psychiatric vulnerability may include proneness to anxiety or mood disorders. Inadequate environmental support may include emotional neglect or lack of parental responsiveness, sometimes resulting from the parents' proneness to go into the fight-flight-freeze mode rather than mentalizing in relation to their children's needs. At worst, in a traumatic situation, mentalizing can be frightening to the child: the parent's animosity or indifference can be frightening, so the child avoids awareness of the parent's state of mind.

In such adverse circumstances, the child can learn to inhibit mentalizing. Interactions in adulthood that remind the individual of earlier trauma, or the arousal of certain distressing feelings, serve as a trigger: mentalizing is inhibited. Then behavior becomes rigid. Rather than engaging flexibly in mutual understanding, relationships are undermined by coercive behavior that provides an illusion of control.

For example, one of us worked with a speech and hearing therapist who was extremely sensitive to subtle nuances in conversation. She had been at odds with her husband for a number of years, but she felt extremely insecure and terrified that he would leave her. She coped by remaining emotionally remote from him, and he had come to believe that she had little investment in the relationship. With great encouragement in her therapy, and with much trepidation, she managed to tell her husband in a planned telephone call that she cared for him a great deal and wished for greater closeness. With her highly attuned ear for speech, she detected a split-second pause before he responded positively to her expressed need. She ignored the content of what he said, experiencing his barely perceptible hesitation as a rejection. She flew into a rage, demanding that he be more responsive and caring. Unable to mentalize, she became coercive. She heard rejection. She felt humiliated, but could not tolerate her own emotion. She could not see the situation realistically. She could not consider,

for example, that her husband may have been taken aback momentarily by her uncommonly open expression of need.

Rather than being an opportunity for a positive change in the relationship, the failure of mentalizing merely reinforced the old pattern. Her husband, having felt he responded positively, launched into a tirade of his own, feeling his efforts were never enough. His response only reinforced her original assumptions, and they both remained stuck.

This example illustrates the central processes—and the critical dilemma—facing persons with a personality disorder: Their adaptation to their particular history of adversity, to their unique biological and psychosocial vulnerabilities, as well as to their strengths and skills, consists of a special sensitivity to certain interpersonal situations and feeling states. These situations trigger a series of coping responses that entail inhibiting mentalizing and activating rigid, non-mentalizing patterns of behavior, often with an addictive quality. These patterns of rigid, non-mentalizing behavior are directed toward two goals: first, they create an illusory sense of control and self-regulation; second, they evoke responses from others that sustain at least a semblance of attachment.

Examples of non-mentalizing or addictive patterns are anger and distancing evoked by feelings of vulnerability and bingeing on alcohol that is brought about by loneliness and depression. These patterns succeed in the limited sense that they evoke responses from others that reinforce the person's maladaptive pattern. Thus such personality patterns tend to be self-reinforcing and self-perpetuating.

Perhaps most tragically, these patterns are typically intensified at times of crisis. When we feel stressed, we all do *more* of what we know how to do. Consequently, we are less able to respond adaptively to the crisis. Unfortunately, efforts to seek help in treatment relationships can run into the same problems, as the same patterns are likely to be played out.

The ultimate dilemma persons with personality disorders face is the following: however maladaptive, their coping strategies and relationship patterns have been essential to their emotional—and at times physical—survival, as well as to their identity and to their attachments. It is not easy to relinquish these strategies in exchange for uncertain rewards. Thus the process of gaining real mastery and control along with genuine attachments is fraught with immense anxiety and requires tremendous courage.

Mentalizing Too Much

One could argue that it is not a good thing to have too much money, but it's hard to imagine that it's not a good thing to have too much ability—intelligence, musical talent or mentalizing capacity. But a gifted musician should not be practicing the piano 18 hours a day. So too with mentalizing.

Although much of our therapeutic energy goes into fostering mentalizing, we also know that there can be too much of a good thing. There are two ways of coping with troubling mental states in oneself and others—trying not to think about them or being inordinately alert to them, continuously braced for danger.

Exquisite sensitivity to others' mental states can leave you vulnerable to painful emotional contagion, as well as to self-sacrificing efforts to rescue others from their pain. And too much mentalizing can lead to a life out of balance. True, as Socrates famously declared, the unexamined life is not worth living. But self-preoccupation goes too far in the other direction, and the overly-examined life also may not be worth living. Although we can do nothing without it, there is more to life than the human mind. Sometimes we just need to plant flowers or mow the lawn.

And being able to turn off mentalizing is crucial to some interpersonal situations. The dentist who is too attuned to the pain of drilling may be distracted from his task, which ultimately relieves more pain. The executive who must downsize a corporation for the sake of its survival

must set aside mentalizing for a time to get the task done—too much empathy can be paralyzing.

III. Treatment Promotes Mentalizing

We think of psychiatric treatment as providing developmental help when development has gotten stuck. Serious psychiatric disorders are ways of being stuck in repetitive patterns that are self-perpetuating. As we described earlier, substance abuse, depression, posttraumatic stress and personality disorders illustrate problems with mentalizing, and all these disorders demonstrate inflexibility. All these disorders; however, are also adaptations—ways of solving problems. Change always brings anxiety, because anxiety is fundamentally a response to novelty and the unknown. Not surprisingly, persons with psychiatric disorders often cannot get themselves unstuck on their own—they need help. For all of us, with adequate help, it becomes possible to do what we cannot do on our own.

Our capacity to mentalize provides flexibility by allowing us to see ourselves and others from a fresh perspective. When we cannot mentalize flexibly, we need others to help us see things from different perspectives. Think of the child freely exploring the toys in the playroom. We need the same freedom to explore our mind and the minds of others. But this exploration can be frightening, as well as enticing, and we may need help to do it. We need the same climate that enables children to explore calmly and confidently: a sense of security and safety. If we are to explore our mind in the mind of another person, it is essential that the other person be accepting, interested and empathic. And we can hardly feel safe in exploring the mind of another when the other is in a state of fear or rage.

Persons with psychiatric disorders frequently have troubled relationships. Emotionally stormy or conflict-ridden relationships are not conducive to mentalizing, which requires a climate of safety and trust. Sometimes that climate of safety can best be found in treatment settings that are designed to foster and maintain it.

In addition, we believe that positive emotions—interest, enthusiasm, joyfulness and compassion—promote mentalizing. Positive emotions tend to broaden our attention and awareness, in contrast to emotions such as fear and anger, which tend to narrow our attention. Thus, in positive emotional states, our thinking is more flexible and creative. Plainly, psychiatric symptoms and disorders—anxiety and depression, for example—erode our capacity for positive emotion. Hence treatment interventions that restore the capacity for positive emotional states, often in the context of promoting a sense of connection with other persons, will also facilitate mentalizing.

Treatment is designed to promote mentalizing from the point of admission, beginning with the initial assessment. Mentalizing is a skill and, like any other skill, mentalizing requires practice. A number of different treatment interventions, such as various therapies and the inpatient milieu, provide ample opportunities to practice mentalizing in a range of different relationships. In turn, the mentalizing capacities developed through such treatment interventions can put patients in a better position to work on troubled relationships outside the treatment setting, providing their significant others are willing to do so as well. Thus discharge planning is intended to set a platform for the generalization of the skills honed in treatment to the key relationships in life outside treatment.

Consistent with our focus on mentalizing, four broad treatment objectives in the Professionals in Crisis program are as follows:

1. to interrupt the vicious cycles and addictive patterns that reinforce and exacerbate maladjustment;
2. to provide pharmacological, psychotherapeutic and psychoeducational interventions targeting specific psychiatric disorders such as depression, bipolar disorder, posttraumatic stress disorder, other anxiety disorders and addictions;
3. to promote and practice mentalizing generally and, in particular, in the context of the specific interpersonal situations and feelings states in which it becomes inhibited and

4. to initiate **virtuous** cycles based on mentalizing in therapeutic and family relationships such that individuals who have previously been stuck and incapable of using treatment are able to take advantage of treatment in their community and to benefit from the support afforded by their normal social relationships.

Achieving these objectives begins by inviting patients and their family members to form collaborative relationships with members of the treatment team. Mentalizing unfolds only in the give-and-take of reciprocal relationships and is undermined in coercive interactions. When we become engaged in mentalizing, our problems are more amenable to change because of our enhanced ability to use other people's support. Engaged in mentalizing, patients are in a better position to *make choices* regarding the ways they use treatment, relate to others, cope with stress and deal with adversity, challenge and vulnerability.

The treatment plan for each individual will differ and involve different combinations of individual and group interventions and pharmacotherapy. Yet, all interventions have three aims in common: first, to enhance mentalizing and the sense of agency and choice; second, to strengthen control and capacity for self-regulation; and third, to promote awareness of one's own and other persons' mental states.

Initial Assessment

Treatment begins with a comprehensive assessment, conducted by members of different professional disciplines, including psychiatry, psychology, social work, nursing, addictions counselors, activities therapists and rehabilitation specialists. This assessment is intended to reveal significant areas of strength, as well as difficulty. In particular, the assessment will be directed toward clarifying the psychiatric disorders and interpersonal contexts or triggers that interfere with the process of mentalizing.

From the start, the assessment process calls on mentalizing—making sense of difficulties in the context of a relationship. The process of mentalizing is going well when patients feel felt, having a sense that their clinician has their mind in mind. Mentalizing is built around communication—not just in words, but also in feelings as communicated in facial expression and body posture. Although mentalizing is mainly intuitive, assessment and treatment revolves around putting these intuitions into words. The process is one of dialogue, where mentalizing involves making oneself understood. Clinicians invite patients to join in mentalizing with an invitation like, "If I am hearing you correctly, what you are telling me is?." Plainly, this kind of assessment continues throughout treatment, and all treatment interventions depend on this process of mutual understanding.

Rounds

In rounds, patients and their treatment team members convene to coordinate the treatment process. We consider rounds to be a *mentalizing extravaganza*. Several individuals are engaged in the process of mentalizing, each from a different perspective. The essence of mentalizing is viewing actions from multiple perspectives, in effect, playing with different possibilities in arriving at a shared understanding. Rounds provides an opportunity for understanding and misunderstanding. Misunderstandings provide a golden opportunity for mentalizing, much of which involves reconciling different perspectives and viewpoints. The goal is not to arrive at the correct understanding, but rather to learn to *engage in the process* of mutual understanding.

Psychoeducation

We participate in formal education beginning in childhood, with most of this education centered upon academic skills and preparation for employment and careers. We also are exposed to some education for other life skills--driver's education and sex education, for example. We also need to be educated about our physical health, for example, understanding something about proper nutrition. And when we develop a major physical illness, we need to understand the illness and its treatment. If you have a heart attack, you must learn about medication, diet and optimal activity levels.

Similarly, education plays a major role in psychiatric treatment. Ideally, patients should know their diagnoses, understand their illness and be informed about treatment options. Understanding mental illness entails mentalizing—making sense of mental experience. The term, mental illness, highlights a problem with mentalizing. Something has gone awry with the mind, and we need to understand it. These illnesses are often frightening and baffling, leaving patients feeling out of control of their mental states. When experience doesn't make sense, they may feel "crazy." Just understanding these various illnesses—although it is no small feat—can provide a greater sense of control. Knowing that you are having a panic attack and not a heart attack is mentalizing, and this knowledge is crucial in learning to cope.

And it is crucial not just to understand illness, but also to understand treatment. As this article attests, we believe that understanding the process of mentalizing provides an orientation to the various treatment interventions we offer.

Individual, Group & Family Therapy

Individual psychotherapy is perhaps the best analogue of a secure attachment relationship that has the potential to foster mentalizing. Much of psychotherapy is devoted to exploring thoughts, feelings, needs, desires and conflicts. And psychotherapy will be conducive to this exploration only to the extent that it provides a safe relationship climate. Of course, trust in a psychotherapy relationship, like any other relationship, cannot be taken for granted. Plainly, many persons seek psychotherapy because of problems with trust, and there is no reason to believe that the therapist automatically will be exempt from distrust. For many persons, needed trust emerges only gradually, based on positive experience. And trust will evolve largely to the extent that the climate is conducive to mentalizing, which is the foundation of feeling understood and accepted. Feeling understood stems from the experience of another person having your mind in mind, and much of this goes beyond words. When all goes well, we feel felt.

We might think of therapists and other clinicians as providing social biofeedback. In the process, patients may become aware of previously unrecognized emotions, needs and conflicts. They may recognize the meaning behind certain states or actions. For example, they might recognize that feeling suicidal expresses some unmet need or unacknowledged feeling.

Group psychotherapy also mirrors earlier developmental opportunities by providing a social network that is potentially conducive to mentalizing. In groups, the opportunities to explore one's own mind and the mind of others are unparalleled. Group psychotherapy provides an especially rich opportunity to appreciate the impact of one's behavior on others, which combines self-awareness with awareness of others. Just as we know with individual relationships, however, a group will be conducive to open exploration only to the extent that the group provides a safe and accepting climate. A cohesive group provides a sense of belonging that supports such exploration.

Marital and family therapy provide a unique opportunity to foster mentalizing in relationships with family members—an arena where mentalizing may be especially challenging, but also especially crucial. Family therapists universally emphasize the importance of open communication. Ideally, each family member is able to express what is on his or her mind, and other family members are open to listening. Often, we mentalize in relation to our own mind by expressing ourselves; we know what we think only after we've said it. And we mentalize others by listening. We achieve mutual understanding through dialogue. The process is the same in individual, group or family therapy. But the impediments to mentalizing are often most conspicuous in family relationships, and marital and family therapy may provide the best opportunity to facilitate this process. Anxiety, which is a common impediment to mentalizing, is often at its peak in interactions with family members. Intense feelings can escalate rapidly in all family members, resulting in more heat than light. The clinician can serve as a mediator, fostering the process of mentalizing in all family members. And the clinician can also serve as a model of mentalizing in the face of intense emotions. Learning to mentalize emotionally in the context of family interactions provides the most direct opportunity to generalize what is learned in treatment to life after treatment.

Addiction Treatment & Support Groups

Addictions are procedural, automatic patterns of behavior that involve psychological dependence, often along with physiological dependence. It is important to appreciate that addictive patterns can be modified only on the basis of an unequivocal commitment to stop using: one must first "walk the walk," which requires actions that confront the secretiveness, denial and self-deception that result from and reinforce all addictive disorders. Thus the Professionals in Crisis program expects patients to agree to stop using and encourages them to attend community support groups such as 12-step groups. These groups offer support for the commitment to sobriety and call for acceptance of helplessness in controlling addictive patterns. Refraining from the addictive behavior opens the door to experiencing previously bypassed feelings and, thus, to mentalizing.

Milieu Treatment

Although group therapy is a primary forum for interpersonal learning, group living more generally expands these opportunities enormously by providing innumerable informal interactions and relationships. For example, running into conflicts with others is inevitable in a close living situation. Yet a climate conducive to discussing these conflicts, receiving feedback and resolving them where possible provides unique opportunities for mentalizing. And developing close relationships with persons of similar backgrounds and in similar straits provides unparalleled opportunities for mutual understanding.

Although opportunities to mentalize abound in the milieu, the potential for interpersonal and psychological problems in which patients need help with mentalizing also abound, day and night. It is helpful to explore these problems in scheduled therapies and groups, but many problems are best dealt with on the spot. Members of the nursing staff play a key role in fostering mentalizing throughout the day and throughout treatment.

Medication

Taking psychiatric medication may seem far afield from mentalizing, but it is often crucially helpful. Mentalizing is the most complex form of reasoning we engage in. In fact, recent evolutionary theory proposes that our complex brain, and the neocortex in particular, evolved because of the sheer complexity of having to make sense of each other and our relationships. To mentalize, we need to be able to think straight. And, as we all know from personal experience, we can't think straight when we're highly distressed. Complex problem solving is impossible under those conditions. Thus we need to be relatively calm to mentalize. Plainly, problems with mood, anxiety and thought processes will interfere with all manners of thinking, mentalizing included. Psychiatric medications are often helpful in regulating mood, anxiety and thought processes, hence the medications may be crucial in facilitating mentalizing.

Discharge Planning & Wellness

We have emphasized throughout that mentalizing is a skill to be practiced. We aim to structure treatment so as to provide a climate conducive to practice. As we have described, mentalizing promotes resilience, the capacity to cope with adversity and challenges.

To a great extent, discharge planning entails preparation for implementing the skills learned in treatment after discharge. This entails using the capacities for self-understanding, understanding others and establishing the kinds of relationships—more secure attachments—in which mentalizing can flourish. Discharge planning also involves ensuring that needed treatment supports to facilitate this ongoing use of skills are in place.

The Therapeutic Bargain

In all individual and group interventions, we aspire to appreciate the *adaptive* functions served by even the most seemingly destructive patterns of addictive and non-mentalizing behaviors. These behavioral patterns provide momentary relief and an illusory sense of control, safety and attachment. The choice to attempt to relinquish these patterns of behavior—the choice, for example, to stop responding automatically to feelings of vulnerability with rage or the choice to make a commitment to sobriety—is naturally fraught with uncertainty and anxiety. These are difficult choices to make, particularly for persons who have based their identity, relationships and adaptation on the selective inhibition of mentalizing as a way to remain unaware of their

own vulnerabilities. The treatment program recognizes that, as much as patients wish to change, they are also reluctant to give up patterns of coping and relating that are familiar and have been effective in providing them with a sense of safety, control and human connection—notwithstanding how much pain and maladjustment these patterns have caused.

Treatment can free patients to examine the price they pay for relying on addictive and non-mentalizing patterns of coping and relating. Such self-examination lets patients struggle with the therapeutic bargain at the heart of the treatment process: the laborious process replacing illusions of control and connection based on addictive and non-mentalizing patterns with real mastery and genuine attachments.

Coda: Mentalizing & Insight

In focusing on mentalizing, we are emphasizing the cultivation of a skill—skill in understanding yourself and others. We place more importance on using the skill than on attaining any particular understanding or insight. Making sense of ourselves is a lifelong process, and our autobiography is always a work in progress. We are not seeking the answer. Rather, we are hoping to foster the capacity to explore freely in search of ever-changing answers. Perhaps more importantly, we are hoping to foster the capacity for mutuality—meeting of minds—that both stems from secure attachments and makes secure attachments possible. Then development becomes unstuck, and a future direction opens up. Choice and a sense of agency gradually take the place of feeling at the mercy of illness.

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