MENTALIZATION AND MENTALIZATION BASED THERAPY

Simona DIACONU*

North East London NHS Foundation Trust, Ilford, United Kingdom

ABSTRACT

Mentalization refers to the ability to reflect upon, and understand one’s state of mind; to have insight into what one is feeling, and why. Mentalization is assumed to be an important coping skill that is necessary for effective emotional regulation. Difficulties with emotional regulation are one of the 4 primary characteristics of all personality disorders. This ability to mentalize is intimately linked up with attachment style

Keywords: mentalization, personality disorders, attachment, emotional regulation.

INTRODUCTION

The mentalization-based therapies have been developed out of a number of intellectual and therapeutic traditions, which include the philosophy of mind, attachment theory and psychoanalysis. MTB (mentalandization-based therapy) represents both an effort to understand how is possible for such a basic human capacity and need (the mentalization) can derail, and also an effort to develop innovative and efficient ways to reestablish and consolidate the individual's ability to reflect both on his thoughts, feelings and desires, and on others'. By doing this, it aims for helping children/adolescents and their families to discover new ways of communicating and relating to each other, and escape their old ways and habits of thinking and acting. The greatest help proves to be the fact that by increasing the mentalization abilities in children who face difficulties such as chronic medical illness or severe family disruption, they are in fact offered the possibility to acquire a new set of life skills. These skills are consolidated by more stable extended social interactions, which are more understanding and supportive.

*Corresponding Author: Simona Diaconu, MD, Speciality doctor in Child and Adolescent Psychiatry, North East London NHS Foundation Trust, Ilford, United Kingdom, email: simona.diaconu@nelft.nhs.uk

The 'mentalization' concept is both a relatively new and a quite old concept at the same time. It has been described as 'a main form of imaginative mental activity, which perceives and interprets human behavior in terms of intentional mental state (e.g. needs, desires, feelings, beliefs, goals, purposes and reasons) [1].

This interesting concept has been developed over the last 20 years by a group of talented clinicians, underlining the fact that this ability to mentalise is a fundamental component of what it means to be human. At the same time, it plays a central role in emotional regulation process as well as in developing a coherent sense of self, [1] and these authors propose the idea that this ability to reflect on our own mental states and others, is essential in the process of therapeutic change in a wide range of treatments, thus becoming the focus of many clinic interventions [2].

One of the most significant things is the fact that mentalizing is right at the core of our humanity and it is reflected in our ability to connect to our own mental state but also to others', in our attempt to understand our own actions based on our intentional mental states, but also others’ actions. Without mentalization there cannot be a robust sense of one's own person, a constructive social interaction or reciprocity in the relations with others or a feeling of personal safety.
Mentalization problems and difficulties in children and adolescents diagnosed with autism and schizophrenia

Imagine a scene from a short film starting with the doorbell ringing. A young and attractive woman, named Sandra opens the door. At the door there is a man about the same age as Sandra who comes in. Sandra says 'hello', and the man asks her if she is surprised. Before Sandra gets the chance to answer, the man tells her how great she looks. He asks her if she had done something with her hair.

Sandra gets her hand through her hair and starts to say something, but the man interrupts her again, telling her that her hair looks very classy. The film ends and you are supposed to answer the following question: 'What does Sandra feel?', having the following choices:
A. her hair does not look very nice
B. she is very pleased about the compliment
C. she is annoyed that the man is so persistent in his advances
D. she feels flattered, but in way caught by surprise.

The scene from the above mentioned film is the first scene from a new and interesting approach that measures mentalization, used in research studies. This measuring tool named the Movie for the assessment of Social cognition [3], makes individuals to watch a short 15-minute film about 4 characters (Sandra, Michael, Betty and Cliff) who meet one night for dinner. Each character presents its own characteristics/traits, different from the others' (e.g. shyness, outgoing, selfishness). The theme of each scene covers friendship and dating issues so that each character experiences various situations during the movie. These situations are meant to arouse mental and emotional states such as: anger, affection, gratitude, jealousy, fear, ambition, embarrassment, shame, and disgust. The relationships between the characters vary in terms of closeness and intimacy (from close friends to strangers) and thus represent different social reference systems where one needs to make mental state inferences.

Of course, the readers of the above scene lack the opportunity to see the facial expressions of the two characters, but if you have guessed the answer as number 4, that in which Sandra feels flattered, but in a way caught by surprise, then, you can consider yourself a good mind reader and having a good mentalization.

The other three answers are mentalization categories in which one does not contain the mentalization or theory of mind (Sandra feels her hair does not look good); another contains less theory of mind or under-mentalization (Sandra is pleased by the compliment); and the last contains an excess of theory of mind or hyper-mentalization (Sandra is annoyed with the man's persistent advances).

On this list one can also add the concepts of the distorted mentalization [4] and the pseudo-mentalization [2]

The lack of mentalizing: are individuals with autism mindblind?

Very often, the term of mentalization is used interchangeably with the theory of mind (ToM).

As an extreme, some researchers see autism as a clinical condition where the theory of mind (ToM) has been 'excised' like a lesion [5] in other words, it is absolutely absent.

The idea that individuals with autism may not have the theory of mind (ToM) has been presented for the first time in the much-cited study of Baron-Cohen and his collaborators in 1985 [6]. In this study, a group of 11-year old children with autism has been compared with a group of age-matched children with Down’s syndrome and with 4-year-old clinically normal children, during a 'false beliefs' task. During the task, a girl named Sally places an object in a basket. Another girl named Anne moves the object from the basket to another place when Sally leaves the room. The participants have been asked where will Sally look for the object when she comes back into the room. The results have showed that, despite the fact that autistic children's mental age was higher than that of Down’s syndrome and normal controls, 80% of the autistic children were not able to show an understanding of Sally's 'false belief' regarding the location of the object, while most of the Down’s syndrome and normal children could. The authors draw the conclusion that autistic children do not have the ability to build theories on the mental content of other people’s mind (true or false beliefs) – a famous deficit called 'mind blindness'[7]
Under-mentalizing: the insufficiency of a good thing

Despite the initial evidence of a complete lack of theory of mind (ToM) associated with autism, the subsequent evidence has shown that a significant number of autistic children and teenagers were able to pass the test of ‘false belief’ [8,9]. Moreover, many ToM researchers have begun to reformulate the concept of total lack, talking now about a continuum, opposed to the initial concept of total lack of it.

For example, Baron-Cohen and his colleagues [10, 11] have developed a mentalization approach where ToM became a lower level module of a vast continuum of the empathy ability. In this approach, the autistic children may be placed along the empathy ability continuum, rather than placed them at the lowest extreme.

Very young autistic children have showed a general lack of social interest, low levels of social engagement and social-communicative exchanges, limited eye-contact and less attention to social stimuli [12]. Moreover, the reduced mentalization continues to be seen in older ages for autistic children. The 2-year old autistic children have a limited ability to imitate, to play imaginative or pretend games or have a symbolic representation of an object [13-15] – a limitation present in even older autistic children [16-18].

These children are less likely to be able to make a distinction between mental and physical and between appearance and reality, and also, they are less likely to understand the functions of the brain or mind [19]. Also, they have a less good performance in ‘seeing-leads-to-knowing test’ [20] and they have more problems in making a distinction between mental and non-mental verbs [21]. These individuals show less spontaneous imaginative and pretend play [22]; they show difficulties in understanding complex mental states; [23] have problems in following the direction of somebody’s gaze [24]; have a reduced insight when they are disappointed [25]; and they have the tendency to mix memories of their own actions with memories of others’ actions [26]. The literature speaks of a reduced mentalization ability in individuals of any age.

Consequently, a large range of interventions has been developed with a common goal: to improve the social communication and interaction of these children, and results, so far, are positive and promising [27-29].

To mentalize or not to mentalize: hyper-mentalizing and under-mentalizing in schizophrenia

The negative symptom cluster of schizophrenia with early onset in adolescence seems to show similar models with those in autism, with a low mentalizing ability [30]. The deficits during the tests for recognition of eyes and faces expressions have been identified in schizophrenia and seem to be similar to those in autism [31]. However, these mentalization failures seem to be a function of the inaccurate inferences of mental states from gaze associated with positive symptoms of schizophrenia, rather than an underdevelopment or absence of mental states attribution ascribed to autistic cognition [32]. Langdon and his colleagues consider the paranoid character of certain positive symptoms of psychosis (such as delirium) as being a form of hyper-mentalization, as the ToM is distorted through several mechanisms: deficit, inflexibility or extreme inferences regarding social clues and hyper-assignment of mental states and intentions [33, 34]. In other words, according to this point of view, individuals with schizophrenia have the tendency to attribute intentions where they do not actually exist.

The curious combination of under- and hyper – mentalizing in schizophrenia has been demonstrated by Langdon - 2005 [35] in a study where schizophrenic individuals were shown ToM drawings which required correct inferences of mental states in order to understand a joke vs. control drawings with non-mentalizing conditions. The schizophrenic individuals have used a less mental-state language than healthy control group in mentalizing conditions, but in non-mentalizing conditions they have assigned incorrect mental states to characters. Langdon and his colleagues [36-38] have explained hyper-mentalizing as coming from their inability to have more perspectives. Thus, the schizophrenic individuals have difficulties in reading mental states (under-mentalizing) of other people and consequently they project their
own paranoid suspicions and biases onto others (hyper-mentalizing).

How does a good mentalization look like? (figure 1)
- A sense of safety in mental exploration and openness to discovery, an inner freedom to explore even the most painful memories and experiences;
- Being aware of the opacity and insecurity of mental states;
- An authentic interest in one’s own mental states as well as in others, and their correlations;
- An adaptive flexibility in switching from automatic to controlled mentalizing;
- Being aware of the change in the mental states, including the awareness of development process of perspective (for example the attachment of one person influences how that person relates both to self and to others);
- Integrating the cognitive and affective traits of self and others (‘embodied mentalization’);
- A sense of realistic predictability and controllability of mental states;
- Ability to control distress in relation to others;
- Ability to be relaxed and flexible and not ‘blocked’ in one point of view;
- Ability to be playful and have humor, which facilitates closeness and not distancing and anger;
- Ability to solve problems following the 'give and take' principle between one’s own perspective and others’ perspective;
- Ability to talk about one’s own experience rather than defining others’ experiences and intentions;
- Willingness to take responsibility for own behavior, rather than the belief that ‘It just happens to me’;
- Curiosity towards the others' expectations and perspectives, rather than the hope that the others will adopt one's point of view.

The strengths of a social relationship:
- Curiosity;
- Safe uncertainty;
- Contemplation and reflection;
- Acceptance of other's perspective;
- Forgiveness;
- Awareness;
- Non-paranoid attitude;

Figure 1. What is mentalization? Model

The focus is on the mental states and not on the behavior. The increase of emotion leads to a decrease in mentalizing.

Mentalization is developed in the context of an attachment relationship [39, 40]. When they are born, babies need their parents/careers to correctly identify their emotional states and adequately respond to them. Parents form an internal representation of the baby as intentional being, and this representation is mirrored by the parent and then internalized by the baby. Thus, in the baby’s mind there will take place a secondary representation.

Theory: the development of the Agentive Self (figure 2)
The attachment figure 'discovers' baby’s mind (subjectivity)

Figure 2. The development of the Agentive Self

The baby internalizes the parental representation in order to form his own
Mentalization and mentalization based therapy

psychological self. Safe, playful and open interaction with the parental figure leads to the integration of primitive models of experiencing internal reality, which is the base of the development of the mentalizing ability [41, 42].

But the mother's ability to make sense of the child's state depends very much on:
- How she feels as a mother;
- How much supported she feels in social relationships;
- What her mother felt about her when she was a baby.

What happens when things go wrong?
When the parent misinterprets the baby's internal state, then she will not be able to correctly reflect the baby's feelings. When the parent is scared because of the baby's distress, what the baby sees and experiences is the fear inside the parent, and thus, the baby will integrate this state of inner stress, which scares the others, finally leading to an inner experience of “I am frightening”.

Theory: the development of the Alien Self (figure 3)

Disorganized attachment
The parent's perception is inaccurate or unmarked or both

Figure 3. The development of the Alien Self

The child, incapable to 'find' himself as an intentional being, internalizes a representation of the other into the self with distorted agentive characteristics.

The alien self
This self is present in each of us in some degree and it leads to the fragmentation (disorganization) of our mental state when our inner world is dominated by this self.

The experience of the Alien Self is similar to inner torment. It is often felt as a deep hatred feeling, inability to feel the pleasure and content of achieving something, the incapacity to appreciate compliments and encouragements from others.

Manipulativeness (and oppositional behavior), as a consequence of a disorganized attachment occurs because the child prefers to externalize the alien part of his self by irritating or rejecting the caregiver (sometimes gently, other times not so gently) in order to experience that mental state of rage and anxiety they had internalized before, but they feel it as alien [43].

Thus, this creates a situation where the child’s unwanted mental state is felt as belonging to somebody else, allowing the individual with a disorganized attachment to experience, in some degree, a level of self-coherence.

The abuse of the child may determine an even deeper complication in this mechanism, when the child uses detached parts of his self in order to obtain an illusory control over the abuser, a process largely described in psychoanalysis as the identification of the victim with the abuser [44]. When the child internalizes the victimizer mental state into the alien self they experience a part of their mind like a torture, inclined to destruct the ego. This leads to an unbearably painful emotional state and the self is felt as being evil and hateful. In this case, it seems that the only solution is to turn the attack within the mind against the body – self-harming.

The mentalization model in order to understand the self-harming behavior
'I just wanted to kill something inside me; this terrible feeling was like a worm eating through my nerves. When I discovered the razor blade and started cutting myself, if you believe me, it was like a new hope. From the beginning, since I was 12, it was like a miracle, a revelation. The blade slid easily, with no pain on my skin, like a knife going through butter. A slide like a ray of light, a cut between what was before and what was after. All the confusion, anger, insecurity and despair vanished in a
second; it was like a moment of coherence, making my self whole again.

A line drawn in the sand stating the idea that finally the body is mine, its flesh and blood is finally under my control.' Fragment from a teenager’s story about his self-harming behavior [45].

The three models of subjectivity that antedate mentalization and can characterize its failure

Psychic equivalence
- Mind – world isomorphism; mental reality is the same with external reality; internal has the power of external;
- Associated with not enough marked mirroring
- Mental experiences can be terrifying (flashbacks);
- Intolerance of alternative perspectives (‘if I think your door was closed because you wanted to reject me, then you really want to reject me’);
- Negative thoughts about one's self are TOO REAL.

Pretend mode
- Ideas do not make any connection between inner and outer reality, mental world is completely cut off from external reality;
- Associated with non-contingent mirroring;
- Associated with feelings of emptiness, meaninglessness and dissociation in the wake of trauma;
- In therapy endless and inconsistent discussions about thoughts and feelings;
  - Simultaneously held contradictory beliefs;
  - Affects that do not accompany thoughts;
- The teleological thinking (focused only on purpose)
  - Worries related to the others, but they only refer to the physical aspect;
  - Focus on understanding actions in physical terms rather than on a mental outcome;
  - Patients cannot accept anything other than a change on the physical level as a true index of the intentions of the other.
- The therapist's attitude, his motivation to help must be shown only by 'heroic acts';
- The therapist must be available on the phone at any time – extra therapy meetings/sessions on the weekends – physical contact – hugs – serious violations of the therapy boundaries.

Examples of non-mentalization

Concrete mentalizing
- It incorporates the psychic equivalents and the teleological thinking

Pseudo-mentalizing
- Pretend mode;
- Intrusive mentalizing;
- Overactive mentalization;

Misuse of mentalization

Specific mentalizing difficulties – I.

Concrete mentalization

The most common factor
- Conversations focused on concrete concerns 'who did what' and explanations about behavior in terms of physical circumstances and influences.

Typical problems (focus for therapy)
- Difficulties in acknowledging/identifying emotions – does not understand the positive or negative emotions;
- Confusing a feeling with a thought – 'Because I am sad the world is a miserable place' (the purpose of mentalization is to be able to feel sad without drawing a conclusion out of it). This confusion happens because the child in psychic equivalence notice what he feels and decides that this must be the external reality;
- Understanding behavior in "concrete" terms – E.g. In terms of external circumstances or behaviors rather than in terms of internal states; 'he got involved in the conflict because it was hot outside', without being able to identify the fact that the person was angry and had difficulties in listening the other's opinion;
- Difficulties in observing one's own feelings and thoughts – plus difficulties in identifying changes in these thoughts or feelings or even changing them;
- Not acknowledging the impact of one's own thoughts, feelings and actions on the others – manifested as insensitivity to others' emotional needs;
- Inability to see how one thing has led to another – for ex. How a thought triggers a feeling, which further leads to an action and that to a reaction from others;
- Over-generalizing starting from mental states
- For ex. Feeling that because something unimportant but upsetting happened, everything has gone wrong;
- The inability to be flexible – for ex. Difficulties in playing with different ways of thinking about situations;
- The feeling that somebody else’s thoughts are dangerous – for ex. If somebody argues with you that means your point of view is bad or that that person hates you;
- Difficulties in associating thoughts with reality – for ex. The individual in this case has the tendency to think in unproductive circles that only increase the anxiety even more;
- Acting without thinking or even avoiding thinking.

**Pseudo-mentalization**

The most common indicator - inaccurate mentalization – there is an apparent thinking, which lacks some essential characteristics in order to be an efficient mentalization; there is a partial understanding which has some truths in it. The pseudo-mentalization implies the use of the mentalization in order to manipulate and control the others' behavior, which is the opposite of an efficient mentalization that reflects genuine curiosity and respect for the others' mind.

**Typical problems (focus for therapy):**

- In general it is characterized by CERTAINTY:
  - About others' thoughts and feelings;
  - About the possibility of knowing what goes on in someone else's minds;
  - The limitation or absence in appreciating the experience shared by somebody else about what is going on in their mind;
  - Thoughts and feelings, both one's own and others', are identified as long as they are consistent with own interests and preferences;
  - Lack of ability to recognize the ambivalence of feelings or of the child's need to present a distorted image of his/her own feelings only to please the adult.
- Preserving a developmentally early view of the child/parent
- Refuse to accept changes in the child's mental state.
- Intrusive mentalizing
  - To pretend that you know everything possible about the thoughts and feelings of others so much that it becomes stressing for the person whose mind is being 'read', so that that person avoids to act or react.

The abusive and inappropriate use of mentalization

The most common indicator – The understanding of the individual's mental state is not directly affected, however, the way in which he uses it is in the detriment of mentalization – especially in the way in which the child directly experiences it. Consciously or not, the way in which it is used is influenced by purposes, wishes and interests of an individual, a dyad or the family as a whole. It is frequently seen in the children when the parents go through a divorce or marital separation; the child's feelings are distorted and used by both parents as ammunition in the fight between them.

**Typical problems (focus for therapy):**

- Manipulative use of true understanding of the child– Which is the most typical context? - 'You are such a jerk! You never think of the way the kids feel when you come home late! Johnny was very upset and disappointed because he waited up for you to show the football trophy he had won. When you didn't show up, he felt like you don't care about him. Maybe you shouldn't bother to come at all anymore!'

- Distorting the child's feelings in order to serve the parent's own interests – The father is critical and complains to the wife – 'When you go to work, the children feel neglected, rejected and unimportant to you!'...But the husband makes these complaints only during the work days when he is asked to have more responsibilities related to the children, but he does not do this when the nanny is present and helps him.

- Coercion of the child's thoughts and feelings
  - By deliberate humiliation of the child's thoughts and feelings. For ex. the parent exposes the child's thoughts and feelings related to sexuality in a family gathering or even individually to the child but in an insulting and insensitive manner. Often this is a power abuse.

I sum up with a mentalization exercise, which can be used both to explore this ability and also to improve it.

**Exercise: Mentalizing 'for better and worse'**

The structure of the 'for better and worse' exercise
Table I. Mentalizing ‘for better and worse’

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<tr>
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<th>Normal mentalizing</th>
<th>New and improved mentalizing</th>
<th>Impaired mentalizing</th>
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<tbody>
<tr>
<td>Self: I think</td>
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</tr>
<tr>
<td>Self: I feel</td>
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</tr>
<tr>
<td>Others: He/she thinks</td>
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<tr>
<td>Others: He/she feels</td>
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The patients are asked to think about a certain relationship and situation that would represent a challenge for mentalizing.

In the ‘normal mentalizing’ category, they are asked to say what they would normally mentalize in relation to the situation (what they think and feel and what they think the other person thinks and feels).

Then in the ‘new and improved mentalizing’ they are asked to extend and improve their self-awareness (for ex. What else they might have felt that they were not aware of) and to imagine other possibilities related to the other person's thoughts and feelings.

And finally, in the 'Impaired mentalizing' category, they indicate how their mentalizing ability decreases in the face of difficulties (e.g. intense emotional states such as anger).

CONCLUSIONS

Dysfunctional mentalization, which leads to disorders of self-experience, occurs in all severe disorders, fact which calls for psychological therapy. The psychotherapist from most trends use mentalization in one way or another, even if they use it explicitly or implicitly, the goal being the same – to increase this mentalizing ability and to improve the patient's quality of life.

Mentalizing is a form of social knowledge, it is a imaginative mental activity, which allows us to perceive and interpret human behavior in terms of intentional mental states.

REFERENCES


Romanian Journal of Child and Adolescent Psychiatry


