What is mentalizing?

- Mentalizing is **perceiving and interpreting behaviour as explained by intentional mental states** (e.g. a belief: *He believes that …*)
- Requires a careful analysis of:
  - Circumstances of actions
  - Prior patterns of behaviour
  - The experiences the individual has been exposed to
- Demands complex cognitive processes, but is mostly preconscious
- Is an imaginative mental activity and is based on assumptions that mental states influence human behaviour

Characteristics of mentalizing

- Central concept is that **internal states (emotions, thoughts, etc.) are opaque**. We make inferences about them
- Inferences are prone to error and so mentalizing easily goes awry
- Mental states (e.g. beliefs), unlike most aspects of the physical world, are relatively readily changeable – e.g. changing one's belief in the light of new evidence
- A focus on the products of mentalizing is more prone to error than focus on physical circumstances because it concerns only a representation of reality rather than reality itself
- Overarching principle of mentalizing is to take an 'inquisitive stance'. This can be defined as *interpersonal behaviour characterized by an expectation that one's mind may be influenced, surprised, changed and enlightened by learning about another's mind*

The mentalizing dimensions: automatic versus controlled

- Automatic
  - Rapid and reflexive process
  - Reduced reflective mentalizing, particularly in the context of attachment activation
  - Higher sensitivity to non-verbal cues inferring others' intentions
  - Day-to-day use
  - Associated with a secure attachment environment
- Controlled
  - Serial and slow process
  - Verbal
  - Requires reflection, attention and effort
  - Used when mentalizing errors and misunderstandings are apparent, interaction requires attention, anxiety or uncertainty, specific contexts

The mentalizing dimensions: self versus other

- Other focus
  - Greater susceptibility to emotional contagion
  - Associated with accuracy in reading the mind of others without any real understanding of own inner world
  - May lead to exploitation and misuse of other, or to being exploited
- Self focus
  - Hypermentalizing of own state
  - Limited interest in or capacity to perceive others' states
  - May lead to self-aggrandizement

The mentalizing dimensions: internal versus external

- Internal
  - Ability to make mental state judgements on the basis of internal states
  - Applies to both self and other
  - Can be associated with hypermentalizing about possible motivations and mind states of others and self
- External
  - Higher sensitivity to non-verbal communication
  - Tendency to make judgements on the basis of external features and perceptions
  - Can lead to rapid assumptions unless checked by internal scrutiny

The mentalizing dimensions: cognitive versus affective

- Cognitive focus
  - Associated with less emotional empathy
  - ‘Mind reading’ seen as an intellectual, rational game
  - Hypermentalizing tendency, devoid of an emotional core
  - Agent-attitude propositional understanding
- Affective focus
  - Oversensitivity to emotional cues
  - Increased susceptibility to emotional contagion
  - Tendency to be overwhelmed by affect when thinking about states of mind
  - Self-affect propositional understanding

Pre-mentalizing modes of subjectivity: psychic equivalence

- Mind–world isomorphism: mental reality equals outer reality
- Internal has the same power as the external; thoughts are felt as real
- Subjective experience of mind can be terrifying (e.g. flashbacks)
- Intolerance of alternative perspectives links to concrete understanding
- Self-related negative cognitions may be felt to be ‘too real’ – absence of ‘as if’ quality
- Reflects domination of self:affect state thinking with limited internal focus
- Managed in therapy by clinician avoiding being drawn into non-mentalizing discourse

Pre-mentalizing modes of subjectivity: teleological mode

- A focus on understanding actions in terms of their physical as opposed to mental constraints
- Over-reliance on what is physically observable
- Understanding of self and others in terms of physical behaviours
- Only a modification in the physical world is taken to be a true indicator of the intentions of the other
- Manifest in behaviours that generate observable outcomes
- Extreme external focus; momentary loss of controlled mentalizing
- Misuse of mentalization for teleological ends (e.g. harming others) becomes possible because of lack of implicit as well as explicit mentalizing

Pre-mentalizing modes of subjectivity: pretend mode

- Ideas do not form a bridge between inner and outer reality; the mental world is severed from outer reality
- To the listener, the patient's discourse feels empty, meaningless, inconsequential, circular
- Marked by simultaneously held contradictory beliefs
- Frequently, affects do not match the content of thoughts
- 'Dissociation' of thought, hypermentalizing or pseudomentalizing are apparent
- Reflects explicit mentalizing being dominated by an implicit, inadequate internal focus
- Poor belief-desire reasoning and vulnerability to fusion with others
- Managed in therapy by interrupting non-mentalizing process when it occurs

The alien self: practice points (1)

- Clinician must be alert to subjective experiences indicating discontinuities in self-structure (e.g. a sense of having a wish/belief/feeling that does not ‘feel like their own’)
- Discontinuity in the self will have an aversive aspect to most patients – leads to a sense of discontinuity in identity (*identity diffusion*)
- Patients deal with discontinuous aspects of their experience by externalization (generating the feeling within the therapist) – so the clinician must actively monitor his/her feelings for this
- Tendency to externalization is usually established early in childhood and deeply entrenched
- Externalization is not reversed simply by bringing conscious attention to the process; it is futile to see these states of minds as if they were manifestations of a dynamic unconscious
- Technically, there is no interpretation of unconscious process

The alien self: practice points (2)

- In patients who have experienced maltreatment, abuse or severe neglect, disowned mental states may include the internalization of a malevolent state of mind
- The patient's experience is of a hostile/persecutory state that must be 'got rid of' to stop the experience of attack by the self from within
- This process is a matter of self survival – 'life or death'
- Patient is given limited opportunity to create relationships where they involve the other in enactments
- The degree to which patients engage in externalization of the alien self must be carefully controlled; too many regressive enactments will undermine any opportunity for using that relationship to enhance mentalizing

Epistemic trust (1)

- A human-specific, cue-driven social cognitive adaptation of mutual design dedicated to ensure efficient transfer of relevant cultural knowledge
- Humans are predisposed to ‘teach’ and ‘learn’ new and relevant cultural information from each other
- Human communication is specifically adapted to allow the transmission of:
  - Cognitively opaque cultural knowledge
  - Kind-generalizable generic knowledge
  - Shared cultural knowledge

Epistemic trust (2)

- Attachment to person who responded sensitively in early development provides a special condition for generating epistemic trust – provides cognitive advantage of security
- Communication that is ‘marked’ by recognition of the listener as an intentional agent will increase epistemic trust and the likelihood of the communication being coded as:
  - Relevant to the listener
  - Generalizable to situations beyond the immediate one
  - To be retained in memory as relevant
- Ostensive cues trigger epistemic trust, which triggers a special kind of attention to knowledge that is understood as relevant to ‘me’

Receptivity to learning triggered by ostensive-communicative cues

- Examples of ostensive communication cues from caregiver to infant/child:
  - Eye contact
  - Turn-taking contingent reactivity
  - Special tone of voice (‘motherese’) to address the child
- Ostensive cues function:
  - To signal that the caregiver has a communicative intention addressed to the infant/child
  - To get across new and relevant information

Epistemic mistrust

- **Not believing what one is told**
- High levels of *epistemic vigilance* (the over-interpretation of motives and a possible consequence of hypermentalizing)
- Recipient of a communication assumes that the communicator's intentions are other than those declared; this means that the communication is not treated as coming from a deferential source
- Misattribution of intention and seeing the reason's for someone's actions as malevolent communication is treated with *epistemic hypervigilance*, or *excessive epistemic trust*
- Process of modifying stable beliefs about the world (oneself in relation to others) remains closed

Epistemic mistrust and personality disorder

- Social adversity (most profoundly, trauma following neglect) causes destruction of trust in social knowledge of all kinds – manifests as rigidity, individual is ‘hard to reach’
- The individual cannot change because he/she is unable to accept new information as relevant to other social contexts (i.e. to generalize)
- Personality disorder is not a ‘disorder of personality’ but an *inaccessibility to cultural communication relevant to the self from the social context*:
  - Partner
  - Therapist
  - Teacher

  } epistemic mistrust

Epistemic trust and nature of psychopathology

- Epistemic mistrust is epistemic ‘hunger’ combined with mistrust
- Clinicians ignore this knowledge at their peril!
- Personality disorder is a failure of communication:
  - It is *not* a failure of the individual, but a failure of learning relationships (patient is ‘hard to reach’)
  - It is associated with an unbearable sense of isolation in the patient, generated by epistemic mistrust
  - Clinician’s inability to communicate with the patient causes frustration in clinician and a tendency to blame the patient
  - Clinician feels that the patient is not listening, but the reality is that the patient finds it hard to trust and consider the truth or otherwise of what he/she hears

Three therapeutic communication systems

- All three address the epistemic mistrust of patients with BPD
- Communication System 1: Communication of therapeutic model-based content
  - This varies according to the treatment model (e.g. MBT vs. DBT)
  - Serves as an ostensive cue that increases the patient's epistemic trust and thus acts as a catalyst for therapeutic success ('therapeutic alliance by any other name')
- Communication System 2: Mentalizing as a common factor
  - The therapeutic setting serves to increase the patient's mentalizing
- Communication System 3: Social learning in the context of epistemic trust
  - The patient applies his/her restored mentalizing in the wider (social) environment, which reinforces and builds upon what he/she has learned in therapy

Communication System 1 and MBT

MBT requires the clinician and patient to:

- Develop a collaborative formulation with the patient early in the assessment process
- Identify mentalizing vulnerabilities using examples that are personal to the patient
- Discuss the patient's diagnosis in terms of the patient's symptoms and history
- Map attachment patterns and how they play out in current relationships
- Engage the patient in an introductory phase, which combines psychoeducation with some interpersonal process
- Establish a developmental narrative of the patient's problems
- Jointly agree goals that are relevant to the patient

Communication System 2 and MBT

- Authentic ‘not-knowing’ stance that forms the bedrock for exploration of the patient’s perspective
- Empathic validation
- Establishing a shared affective platform held between patient and clinician
- Focus on the principle that another mind can be useful to clarify mental states and increase a sense of agency
- Increasing focus on affect and interpersonal interaction – both during a session and over time
- Attachment context in which to explore ever more complex states of mind that would normally trigger loss of mentalizing
- Mind of the clinician is ‘open’ to the patient
- Subjectivity is held to be of importance and not subjugated
- Patient has to consider the clinician’s viewpoint, just as the clinician has to consider the patient’s
- Perspectives are expected to change when new information becomes available; minds change minds in a transactional manner

Communication System 3 and MBT

- Stabilization of patient's wider social context
- Exploration of patient's current relationships outside the therapeutic relationship
- Focus on sensitive responses from others
- Recognition that negative responses are no more than that
- Emphasis on self-agency and self-determination
- Openness to others' states of mind, including those of the clinician