

## RESEARCH ARTICLE

# Mentalisation- Based Therapeutic Interventions for Families

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## ABSTRACT

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

**KEY WORDS:** mentalization based psychotherapy, mentalization based family therapy

## **Introduction**

The terms 'mentalization' and 'mentalizing' are often used interchangeably. The latter - derived from the verb 'to mentalize' - perhaps more accurately captures the idea that we are concerned with an ongoing activity rather than a fixed state of mind or an individual characteristic. Mentalizing is a process and it generally occurs without effort or specific consciousness. It can be summarised as seeing ourselves from the outside and others from the inside. Mentalizing (Fonagy et al, 1991) refers to the attitude and skills involved in understanding mental states, both one's own as well as those of others, and their connections with feelings and behaviour. The recursive character of this process, namely the inter-linking of mental states and how they continuously influence each other, would seem to recommend it to a systemic approach. In this paper we argue that employing a mentalizing 'lens' when undertaking systemic work has the potential to enrich practice. The emerging approach of Mentalization-Based Therapy for Families (MBT-F) (e.g. Asen & Fonagy, in press; Fearon et al., 2006) is placed within the context of systemic work and the reader is encouraged to consider the question of whether this is an altogether new approach or merely an add-on to already familiar systemic approaches. This paper could equally well be presented as a mentalizing approach to systemic thinking or a systemic perspective on mentalizing. Throughout our collaboration we have been struck by the common themes, including a shared epistemology underpinning these approaches. Here we will consider MBT-F from a systemic perspective.

Systemic practice has undergone many changes over the past 60 years. The 'self' of the therapist has come into focus (Rober 1999) and, in line with this, systemic practitioners have begun to link the intra-personal and inter-personal worlds (Fraenkel & Pinsof, 2001; Flaskas, 2002). The time seems to have come to review ideas and concepts from the psychoanalytic world. Mentalization-based work with individuals diagnosed with borderline personality disorder (Bateman &

Fonagy, 2006) awakened the interest of systemic therapists in the concept of mentalizing. In turn, clinicians involved in developing mentalization-based approaches could see that they and their systemic 'relatives' had much in common. This is how the development of MBT-F began a few years ago.

### **The mentalizing background**

No animal, not even the most intelligent of non-human primates, can discern the difference between the act of an 'other' due to chance and one rooted in intention, wish, belief or desire. We humans, by contrast, automatically - and utterly without reflection - seek to find 'meaning' behind a person's action in terms of the '*mental state*' that might have motivated this action. This capacity to mentalize, which is gradually developed from infancy onwards in interaction with the primary carer giver(s), has also been argued to account for other major differences between humans and other apes, such as self awareness and self-consciousness. It could be said that we needed to be self aware in order to understand others through simulation (Gordon, 1986, 1987; Harris, 2009). To anticipate someone's actions we may imagine ourselves into their position but for this we need self-awareness which is of course mentalizing applied to oneself. Of course awareness of mental states brings with it 'valuable' social emotions such as embarrassment, shame and guilt. More positively, conceiving of 'mind' perhaps enabled humans to strive to be more than 'beasts', to live beyond their body, to aspire to a spirit that transcends physical reality and step beyond their own physical existence. In line also with systemic thinking, the focus on mental states as generating behaviour brings the social origin of the 'self' into relief: the recognition of oneself in the mental state of the other lies at the root of the sense of personal selfhood (see Allen et al, 2008 for a more comprehensive review of the concept).

A 'good enough' perception of one's own state is evidently essential for a balanced inner life and we can experience a 'loss of calibration' of internal experience (not knowing how seriously to take one's subjectivity) as mental disorder. It should be emphasised that effective mentalizing describes not only the capacity to accurately read one's own or another person's states of mind, thoughts and feelings, but also a way of approaching relationships which reflects an expectation that one's own thinking and feelings may be enlightened, enriched and changed through learning about the mental states of other people and a readiness to take into account their perspectives, needs and feelings. This attitude is characterised by an inquiring and respectful stance in relation to other people's mental states akin to the systemic stance of 'curiosity' (Cecchin, 1987), with an awareness of the limits of one's knowledge of others. Mentalizing is, by definition, inexact and developing an accurate picture of others' states of mind requires constant social verification. Mentalizing is developmental, increasingly complex and only gradually fully achieved. Orientation to other minds is part of the behavioural repertoire of all infants and the developmental pathway of mentalizing is reasonably well charted (Sharp et al , 2008). The increasing sophistication of mentalizing with age speaks to the complexity of the process and it is important to keep this multifaceted nature in mind when applying this idea in therapeutic work.

The development of mentalizing capacity occurs in the context of attachment relationships and disruptions of attachment can create a developmental vulnerability for a failure of complex meta-cognitive capacities (Fonagy & Target, 1997). However, the relationship between attachment and mentalizing is bidirectional, as the inability to represent the mental state of the self, attentional problems, and difficulties in reflecting on the mental states of others can obviously disrupt attachment relationships, whereas a poor attachment relationship undermines the natural emergence of mentalizing capacities (Fonagy & Luyten, 2009). The child who is better understood will understand the parents better and the resulting interactions will be more readily understood by

the parent which will in turn enhance the child's mentalizing capacities – a circular process which is very much in line with systemic thinking. Setting aside reductive causal models, we see the family system as providing critical components of the content (understanding the nature of feelings and thoughts) required for the healthy development of mentalizing and for children's evolving capacities to be facilitated or hindered by their relationships with attachment figures as well as by the relationships they observe between family members.

### **Effective mentalization**

MBT-F is based on the idea that strengths in mentalizing need to be enhanced by being identified, validated and developed (Allen et al., 2008). We list several characteristics of effective mentalizing that MBT-F aims to promote and link these to systemic techniques and (implicit) objectives. *Openness to discovery* is similar to what, from a systemic therapist's perspective, is known as *curiosity* (Cecchin, 1987). In MBT-F this refers to an attitude where the individual is genuinely interested in other people's thoughts and feelings and respects the perspectives of others. It includes a reluctance to make assumptions, or hold prejudices, about what others think or feel. The *opaqueness of mental states* (Leslie, 1987) is a similar concept to that of *safe uncertainty* (Mason, 1993) and implies the open acknowledgment by the 'good mentalizer' that one can never *know* but can only *guess* what other people are thinking. It is 'safe' in that this stance does not lead to the person becoming totally perplexed or overwhelmed by what may happen in the minds of others. This confidence is based on a background feeling that the reactions of others are at least to some extent predictable, given the sense one may have of what others may think and feel. *Reflective contemplation* is a mentalizing attitude which conveys a flexible, relaxed and open attitude, rather than a controlled and compulsive pursuit of how others think and feel. The *reflecting team* techniques (Andersen, 1987) capture and enhance this mentalizing strength. *Perspective-taking* is characterised by the

acceptance that the same phenomenon or process can look very different from different perspectives and that these tend to reflect individuals' different experiences and histories. The technique of circular and reflexive interviewing (Selvini Palazzoli et al., 1980) has a similar effect of generating multiple perspectives. There is no obvious systemic equivalent to the notion of *forgiveness*, a mentalizing strength which bases the comprehension of the actions of others on the understanding and acceptance of their mental states. An example of this is the management, if not dissipation, of one's own anger towards a person who was offensive, once one has understood that the other person had acted as they did because of, say, a significant personal loss. *Impact awareness* is another important aspect of successful mentalizing: it refers to the appreciation of how one's own thoughts, feelings and actions may affect others. Systemic practitioners tend to use *tracking questions* to generate impact awareness. Having a *trusting attitude* is an important mentalizing strength and it is in marked contrast to a paranoid, fearful stance which may be incompatible with accurate mentalizing. Systemic practitioners subscribe to a stance of transparency and authenticity and may employ a variety of *joining techniques* (Minuchin, 1974) to generate a context of mutual trust in the therapeutic setting.

*Humility* (moderation) in relation to one's capacity to know and understand someone else and willingness therefore to be surprised and learn from others, regardless of status, follows from many of the strengths described above. Systemic practitioners have adopted the '*one down*' position which if employed in an authentic and not 'strategic' way is similar to a stance of humility. *Playfulness and (self-mocking) humour* gently force alternative perspectives and it can also lead to 'give and take' in interactions with family members and significant others. Systemic practitioners use humour and playfulness to get family members to look at and experience themselves in fresh contexts. The *belief in changeability* implies some degree of optimism and embodies the hope that minds can change minds as well as physical situations. This is analogous to the inappropriateness, within the systemic frame of reference, of talking about a 'treatment resistant

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

### **Systemic difficulties in mentalizing terms**

As well as enhancing effective mentalization, MBT-F also aims to address the difficulties in mentalizing that contribute to relationship problems. The overarching assumption of MBT-F is that difficulties in mentalizing have a pervasive impact on a family's capacity to function effectively, since feeling misunderstood has the potential to create acute distress and chronic distortions of relationships. Mentalizing problems will emerge with different strengths, with differing severity and presentations even in the same family at different times and in particular situations. Difficulties may be relatively mild and specific but can also include non-mentalizing attitudes that have long-term effects on the well-being of individuals and their families. Mentalizing strategies may also be under-used or applied erratically because of other demands or high levels of perceived stress, or if a family member or a relationship has a circumscribed 'blind spot'. At the more extreme end of the spectrum, one or more family members may deliberately or inadvertently misuse mentalization in their dealing with others. Whilst taking note of such impairments of mentalization, MBT-F nevertheless focuses primarily on enhancing mentalizing strengths and does not concern itself with dissecting 'pathological' mentalization patterns, and does not target specific examples of dysfunctional mentalization with the aim of modifying particular

patterns of cognition (as might be the case for cognitive behavioural approaches).

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

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



happen merely in response to thoughts and feelings that trigger high arousal and non-mentalizing 'concrete' reactions. Under such circumstances, high levels of arousal 'switch off the frontal lobes' (the parts of the pre-frontal cortex normally mediating this psychological capacity, Arnsten, 1998). This drastically limits the ability to check and evaluate one's own mental states, and grossly inaccurate or even seemingly malevolent feelings may be attributed to others. As a result, feelings of resentment and mistrust can develop in a relationship context which, in turn, will increase arousal and set in motion a negative circular process. Ultimately, the representation of the minds of others can literally be obliterated and replaced by empty, hostile schematic images. In a contested contact dispute between two estranged parents, for example, a parent can become convinced that their child is siding with the other parent and is being deliberately and maliciously provocative. Disastrously, all too often, the parent's mind becomes closed to seeing the child in any other way, which may force the child to behave according to this 'script', just in order to feel that they are being seen. Another example is an adult who had suffered physical and sexual abuse in childhood who, when faced with a reminder of past trauma, may temporarily have difficulties in mentalizing when experiencing intense states of helplessness, anger or shame. The mother's state of mind may have been triggered by something the child said (e.g. "Mummy, why are you looking at me like that?") and her temporary emotional unavailability for the child generates powerful distress in him (Lyons-Ruth & Jacobovitz, 2008). This in turn intensifies the mother's traumatized dissociative reaction and her traumatic non-mentalizing stance. A child who may generally have had good experiences of feeling thought about and understood, is confused by the parent's sudden inability to appreciate his disappointment and bewilderment.

Other specific family problems of mentalizing can arise if an individual obscures his/her own mental states and thus makes it difficult for others to inquire about and understand the person's state of mind. One example of this is a 9 years old girl whose father has died and whose mother is currently struggling with her own

bereavement. The mother, who has found a new partner, deliberately avoids contemplating the father. The child may feel a strong urge to keep secret her positive feelings for her father and thus try to manage her distress about the loss on her own. The child senses the mother's need to be protected from the intensity of her own feelings of loss. In doing so, the child hides her own feelings and puts on a mask of cheerful competence. This makes it impossible for the mother to tune into her child's sadness yet this leaves her daughter with a sense that she is not understood at all. This circular process illustrates how a systemic issue can be illuminated and elaborated from a mentalizing perspective.

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

intentional states, as the least painful way of coping with what may well amount to the experience of emotional neglect.

In many instances of long-term and enduring mental illness, a dependent child's need to be thought about as thinking and feeling is not met adequately, because the child has to compensate for the parent's limited ability to mentalize their child. As a result, the child may become excessively concerned with mental states in general and early on embark on a pseudo-career as a 'little psychologist' (pseudo-mentalizing), but without the experience of life that would give the attempt at mentalizing substance. These children, who may often be described as 'young carers', in their over-preoccupation with the mental states of others, achieve hyper-reflectiveness about others at the expense of being curiously unreflective about themselves, including denying their own intense feelings. For example, a 12 year old boy to whom it was suggested that he must have had plenty of feelings of anger of being let down by his unwell mother, replied – in a very angry manner – that "I have never felt angry in my whole life". Children often pay a price for being 'excessive mentalizers' of other persons – at the expense of being in tune with their own mental states -, with possibly many ensuing long-term social and developmental difficulties.

Parents, prone to experiencing high levels of arousal, such as those with high trait anxiety or those prone to emotional storms, can find themselves excessively engaged with the child's mental world, anxiously loading the child with their own preoccupations. The child, who does not understand the source of severe parental anxiety will be perturbed by it and search for an explanation in the parents' actions and thoughts and also do so by engaging in excessive mentalizing. In a sense, similar processes appear to take place in the parent and child, almost in parallel but failing to inform each other directly. When these unacknowledged interactions take place in a family context, inevitably this has an impact on everyone, with disconnected but intense efforts all around to mentalize what is going on. When two people in a family session are involved in a dyadic

interaction attempting to drive home their respective points without the ‘curiosity’ that might make the effort genuine and productive, and a child in the midst of this is paralyzed and stops thinking, there will be an attempt by each of the dyad to draw in either the child or the therapist to validate their perceptions of others’ mental states. The child or the therapist is at risk of being recruited into a potentially non-mentalizing interaction as they can only have a partial understanding, if that, of the states of minds of each participant. In this way, a non-mentalizing dyad becomes a triad! The therapist is likely to understand only some aspects of the interactions and, in turn, the protagonists will only have a selective understanding of the therapist’s stance, in all likelihood the one which best corresponds to their own position. At the same time, each person in the dyad will feel invalidated by the aspects which describe the mind state of the other, feeling that they are being sided against. This leads to each person stating their position louder and louder, in a desperate attempt to have their views accepted, but the noise generated makes it increasingly unlikely that anyone within the system can be receptive to others’ perspectives. Gradually, the system can recruit more and more members of the family, as well as professionals, with an ever increasing number of disconnected minds. This is a mentalizing account of ‘symmetrical escalations’ (Watzlawick et al, 1967) which so often undermines mentalizing capacity in ‘helping’ systems that proliferate around families. Just as mentalizing engenders more mentalizing, so non-mentalizing is infectious – it breeds non-mentalizing systems. Awareness of this risk is a powerful source of therapeutic self-protection.

If a member of the family ‘leaves the field’, and becomes unavailable for mentalizing, other family members may show even more extreme ways of non-mentalizing, taking on a stance that directly attacks mentalization. Typical statements may be: “*you are trying to drive me crazy*”, “*your grandma is in league with your father against us*”, “*you provoked me*”, “*you don’t care about whether your Dad is here or not*”, “*you don’t care about me*”, “*you would be glad if I was dead*”. Such statements inevitably generate further arousal that is

incompatible with mentalization and can lead to nothing but further non-mentalizing cycles. Entering into a discussion about the meaning of such statements is almost guaranteed to fail, as these can only make sense in a non-mentalizing world. Therefore a therapist who attempts to question the meaning of such statements inadvertently contributes to the non-mentalizing cycle and at best achieves 'pseudo-mentalization' (see below). Non-mentalizing by definition cannot be interrogated in a mentalizing manner (one cannot reflect on the content of one's own mindlessness). The discourse needs to be shifted from a non-mentalizing to a mentalizing one, most easily perhaps, by retracing one's steps ('rewinding') to where mentalization was last evident. The family narrative can then begin again from that point.

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

We have already talked about the subjective experience of children whose parents are temporarily or chronically unavailable, and how this can generate a kind of 'circular' or cyclic hopelessness. The consequence is a change in each person's quality of experience of their internal states and self-awareness. A person who is depressed may experience her negative thoughts and feelings about herself as entirely real, and lose the perspective that would allow her to think differently about herself, or others, because of an experience of an absence of interest in their state of mind by other family members. In the absence of relational mentalizing strengths, such as curiosity, reflective contemplation and perspective taking, a sense of pessimism that feelings can ever change may take over. A feeling of hopelessness is taken to be a 'physical reality' the moment it is experienced and it cannot be treated as 'just a thought' which might then lend itself to be challenged cognitively. The term '*psychic equivalence*' (Fonagy & Target, 2000) refers to a developmentally immature form of mentalizing when mental states are experienced as having the same status as physical reality. As we know, this is a normal developmental stage for pre-school children, whose

fears cannot be assuaged by reassurance that they are unfounded. It is a stance which, when found in adults, could be paraphrased as: “everything in my mind is out there (i.e. is real and true), and everything that is out there is also in my mind (i.e. known to me)”. Toddlers ‘know’ everything there is to know and everything they know is by definition true. Psychic equivalence can persist in children beyond toddlerhood if mentalizing is insufficiently supported in the family and momentarily return for adults when emotional arousal prevents genuine mentalizing. One’s own thoughts and feelings override those of anyone else. It is sufficient for a person to have the impression that someone else’s action (e.g. looking at their watch) is a clear indication that the person is bored in their presence, for that inevitably to mean that they are hopelessly boring and that this is the only interpretation possible of their behaviour. It is this momentary inability to entertain alternative explanations and perspectives that gives mental states in psychic equivalence such an undue force.

In the state of psychic equivalence, often only what is observable in the physical world is experienced as being significant (Fonagy et al, 2002). There are times when utterly concrete thinking can take over the whole family so that nothing except changes in physical circumstances (i.e. observable outcomes) are felt to be sufficiently real to matter. Specific aspects of behaviours towards each other can acquire undue significance. For example, physical expressions of appreciation, such as the mere act of saying ‘thank you’ or ‘please’, can come to stand for everything that is being encompassed by the mental state of gratitude. It is possible to conceptualize specific systemic techniques, such as concrete changes in the therapy room (e.g. Minuchin, 1974 placing people on different chairs or closer to each other, or having to face each other) that make non-mentalizing families accessible to therapeutic intervention via an alteration in a physical domain with palpable consequences for subjective experience. Reflecting on these will inevitably induce (strengthen) mentalizing. This is the hidden benefit of creating new perspectives and ways of viewing the other.

In families with poor boundaries between the generations - often referred to as enmeshed - some form of intrusive mentalizing can take place. Here the separateness of minds is not respected and family members strongly believe they 'know' what other persons think and feel. The family discourse may indeed sound as if everyone is mentalizing well but, paradoxically, this does not have the usual consequence of people feeling understood. This form of interaction can be described as '*pseudo-mentalization*'. Pseudo-mentalization too has its developmental origins in toddlerhood, when children create imaginary mental worlds that they are able to sustain as long as these are not confronted by physical reality (Target & Fonagy, 1996). When the adult continuation of this 'pretend mode' grips a family, family members will seem to be mentalizing but will fail to connect with anyone else's 'reality' and therefore will be disconnected from each other. This experience may make each person in the family redouble their efforts to have their interpretation of things accepted by everyone. In doing so, more and more unfounded assumptions may be made about other people's mental states. Family members invest a lot of energy in thinking or talking about how everyone thinks or feels, but these ruminations bear little or no relationship to people's actual states of mind. As a result the attempt to mentalize may be experienced as obstructive and confusing and this can block further mentalization efforts altogether. Just as many bacteria become immune to specific antibiotics if these are overused, pseudo-mentalizing can become an insurmountable challenge to a psychotherapeutic intervention.

Another form that misusing mentalization can take is *coercion against a person's thoughts*. For example, a man can undermine his partner's capacity to think by deliberately humiliating her in a family gathering in a belittling and insensitive manner, disclosing something that she might have confided in private. These phenomena are most pernicious in the context of abuse when they serve to undermine the partner's confidence in her self-awareness: "you enjoyed it when I touched you like that". These experiences may undermine confidence in one's subjective experience and the extent that mentalization is felt to be worthwhile.

This is not simply because they directly contradict the person's own experience ("you fell down the stairs, I never hit you") but also because the person may be unable to construct a bearable image of what thoughts must have been in the partner's mind in order for them to make such confusing statements. At the extreme end of the non-mentalizing spectrum is the *misuse of mentalization*. Here the understanding of mental states of self and others is not directly impaired, but is used to further a person's self-interest and at the expense of the well being of the family or one of its members. One example may be how a child's current mental state (e.g. sadness) is being used to provide ammunition in a parental battle (e.g. "whenever you visit your father you feel so sad afterwards, don't you think you should stop seeing him?"). In these situations the child might come to experience the entire category of the activity of mentalizing as aversive because being understood occurs in the context of being manipulated into an undesirable position in relation to loved ones. The child's feelings have been exaggerated or distorted by the parent for her purpose. Another example is a father who criticizes and complains to his wife that her taking a job means that the children feel neglected and rejected and that, as a result, they are evidently suffering. However, he only makes this complaint as he is now required to be more involved at home and has less time for himself.

### **A mentalization focus in systemic therapy**

The therapists' primary focus during this form of treatment is on the thoughts and feelings of each member of the family, and the relationships between them. They acknowledge and positively connote different perspectives, they repeatedly and explicitly check that they have properly understood what somebody means ("*let me just check that I've got this right*"). The therapists show that they cannot know what a member of the family feels without asking a question to find out. They help individuals to communicate and express what they feel, for example by stopping the conversation to ask 'naïve' questions about what it is that the person feels they cannot say or explain. A mentalizing element is added to



linear or blaming statements by family members, such as “he’s always trying to wind me up!” by therapists inquiring: “*and do you think that he is being deliberately annoying?*” The therapists may ask ‘triadic mentalization eliciting’ questions, for example by inviting one of the family members to say something about the relationship between another two people (“*how do you think your parents felt towards each other while you were shouting?*”). ‘What if’ questions are also employed; the therapist might say to a child who had had a tantrum because he wanted his parents to stop the car: “*What would you have felt like if she had stopped the car?*” and to the mother, “*What did you think he would think and feel if you did stop?*” While ‘what if’ questions risk eliciting pseudo-mentalizing from family members in pretend mode, when confronted with the concreteness of psychic equivalence, contemplating alternative perspectives can shift the family’s thinking towards a more mentalizing mode.

Mentalization-focused interventions move from orienting questions, to creating an agreed language for talking about affect. The interpersonal and emotional context of important events are explored by reference to accompanying mental states. This can be quite laborious, as people often want to restate the sequence of events and ‘facts’. Mentalizing strengths are identified and highlighted throughout this process. Therapists themselves may serve as good models for mentalizing when they ask for clarification and reflection, using the sequence of “stop, replay, explore & reflect”. This is particularly useful when faced with stark examples of non-mentalization. Reviewing of the process by which mentalization was impaired or lost is a key effective component of the approach. Unless therapists consciously “stop” to consider the feelings and thoughts at the moment before the loss of mentalization, they may inadvertently feed into the proliferation of a non-mentalizing stance.

We have already stressed that mentalizing therapists take an inquiring and respectful stance in relation to other people’s mental states, conveying that understanding other people’s thoughts and feelings is important. Therapists

communicate this to the family as a whole and help the individual family members to focus on what feelings are experienced by each person, as well as highlighting the ways in which miscommunication or misunderstanding (or lack of understanding) of these feelings leads to interactions that contribute to, or maintain, family problems. In practice, this requires therapists to strike a very careful balance between creating a therapeutic context which allows the family to interact 'naturally', including actively eliciting habitual and possibly problematic family interactions around difficult issues, as well as being directive and intervening at critical moments. Since the MBT-F approach postulates that non-mentalizing interactions are unlikely to produce significant changes in family interactions, merely allowing these interactions to occur is unlikely to be therapeutic. Therefore, once therapists have a clear idea of the core mentalizing problems, and once they have appropriate examples of related interactions to work with, they can intervene (actively bring non-mentalizing interactions to a halt) and shift attention away from non-mentalizing processes. One major aim of MBT-F is to highlight the missing perspective for each family member and how this leads to the behaviour of others not being fully noticed and understood.

We hope it is by now evident that the primary advantage of a focus on mentalizing is that it supports therapists when they find themselves caught in non-mentalizing interchanges within the family. One of the underlying assumptions of MBT-F is the belief that mentalizing is part of a self-righting 'gyroscopic' function of family systems. In other words, MBT-F assumes that many problems within families will be improved (if not fully addressed) if family members' ability to think about each others' states of mind is promoted and freed from obstacles and blockages. The principal danger for therapists lies in the contagious nature of non-mentalizing and the temptation to become engaged with non-mentalizing physical reality oriented interactions when faced with the challenge of contemplating destructive and negative thoughts and feelings that can exist but remain (for good reasons) ignored within family systems. Taking a mentalizing approach is not a panacea to eradicate

impossible family conflicts. Simply drawing the family's attention to putative sources of hostility within the family (a classically psychoanalytic interpretative approach) is unlikely to be successful, as non-mentalizing precludes the genuine contemplation of alternative ideas. An emphasis on mentalization does not radically alter the priorities of a systemic therapist, but it focuses on phenomena that might otherwise be marginalized. It can enhance the effectiveness of systemic therapy by providing a way to get around common blocks in therapy and making family members more receptive to tuning into each others' thoughts and feeling states. The therapist aims to help the family hold on to mentalization in the face of challenges to thinking and contemplating feelings where previously they have not succeeded. In the light of the systemic investments that may be marshaled against this aim it is, in our view, essential that the therapist has a structure to support a mentalizing focus, the framework of which is described in the next section.

### **The mentalizing loop**

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

As a first position, during any stage of any session, the therapist makes a tentative statement (*punctuating*) about an interaction between family members which he has observed in the 'here and now' of the session, e.g. "*I notice that*

*whenever dad talks, Johnny (son) looks anxiously at mum – has anybody else here noticed this? Or am I just imagining this?*” The immediate *checking* with family members (“*has anyone else noticed this?*”) of this observation – which is of course a highly specific and deliberate punctuation of an otherwise complex interaction sequence – is very important in ascertaining whether what the therapist has observed resonates with the family members. In this example the therapist first identifies and highlights an interaction which (to him) appears to be related to some mentalization difficulty. He then checks his observation by inviting the family and its individual members to connect with it, but also giving them the chance to dismiss it. It is possible that some or all family members might, for example, state that they have ‘no idea’ what the therapist is going on about. This should then lead the therapist to reflect on the validity of his punctuation in the light of the feedback obtained and also possibly speculate about the possibility of – and potential reasons for - family members seemingly protecting themselves from the possible implications of the therapist’s observation.

If there is some acknowledgement between family members and they engage with the therapist’s observation, then the important position of *mentalizing the moment* can be taken. The therapist models a mentalizing stance, showing respect for and curiosity about the minds of others. This attitude conveys that learning about how others are thinking and feeling is enlightening: “*what do you think is this about? What do you imagine is Johnny feeling that makes him behave like this? And how does this affect others? Dad, what do you make of it? Maybe I got it all wrong – what do you think Mrs Jones? I wonder, dad, what it feels like for you when Johnny looks at mum in this way? What do you think it feels like for Johnny? If one could see thought bubbles come out of your wife’s head, what might be in there about how she thinks Sally feels right now?*” This invitation to undertake some form of ‘*emotional brainstorming*’ encourages family members to voice feelings, with the therapist then facilitating discussions between family members, rather than merely leaving the action merely between

the therapists and individual members of the family: *“let me see if I got this right – are you saying that when your dad talks like that it makes you feel a bit lost and you look at mum because she is worried? Do you think she is – or does anyone here have a different view? Can you all discuss this with each other?”*

In order to encourage mentalizing by each member of the family, a whole range of different mentalizing techniques can be employed (Asen & Fonagy, in press; Fearon et al., 2006). Overall it is the therapist’s task to slow down the interactions between family members, questioning or expressing a specific interest in exactly what each person is feeling as this interaction unfolds. The aim is to temporarily pause the flow of exchanges between family members and permit further reflections all around. At some stage the therapist will attempt to help family members to *generalize*, moving away from discussing the specific interaction and to widen the ‘lens’. Family members are invited to come up with some more general observations and reflections on how similar interactional patterns tend to evolve spontaneously at home and what feeling states these elicit. *“So we saw that when dad talks, mum feels anxious and Johnny picks this up..... maybe this is the only time it ever happened, but maybe it is not.... Can you talk together about whether you recognize this as something that happens at home or elsewhere”*. Here what has been observed in the ‘here and now’ of the session is ‘looped out’ into ‘real life’ situations, in an attempt to identify and address typical problem situations. This leads to family discussions of problem-relevant situations and the focus remains on eliciting and highlighting emerging feeling states and how these express themselves in behaviours. The therapist actively encourages family members to label their own feelings, to reflect on what that must be like for them: *“you may want to find out how feeling leads to doing”*; *“how a few snowflakes can launch an avalanche”*; *“how a little feeling can get out of control”*.

At a later stage, often towards the end of a session, the therapist will want to *review* what this experience has been like for everyone. Here one looks back

and checks the feeling states of each individual family member. This helps both therapist and family to evaluate how a new and emotionally charged experience has registered with the different individuals, and it provides an opportunity to reflect on what happened and the possible consequences together: *"What did you make of what happened? Can you talk together about what this was like for each and all of you? Are there any conclusions you can draw from this?"*

To follow this mentalizing loop rigorously, or even rigidly, would be a rather non-mentalizing enterprise, possibly even mindless. We have included it here as a model of what is necessary to create and maintain a focus on mentalizing, as mentalizing can be quite 'slippery'. One aspect this paper aims to highlight is that while in therapy there needs to be a deliberate, conscious and consistent focus on mentalizing, this cannot become a routine or be programmed. Almost everybody can mentalize and the occasional piece of mentalizing will not be sufficient when we undertake therapeutic work. It is a difficult task to find a balanced way of mentalizing and each therapist needs to find his or her own frame for it. There can be no 'prescription' for the 'right' amount of mentalizing, as mentalizing refers to a mental attitude rather than a dose of medicine to be dished out at regular intervals. Mentalizing is not an activity or exercise. Caring for one's mind is at least as complex a task as caring for one's body and there is no equivalent for the 'apple a day that keeps the doctor away'. It is a considerable task, both for therapists and families, to take onboard the full implications of using a mentalizing approach. Therapists have to respect the courage and commitment of families when they adopt this way of working. Non-mentalizing is not all that difficult, and on occasion, it is perhaps desirable, but it can be more harmful in the long run. Mentalizing is risky and can be demanding and exhausting. It requires us to give up the illusion of certainty which comes with 'knowing'.

### **Summary of the mentalizing approach to family therapy**

In summary, there are four characteristic features of the stance adopted by the MBT-F therapist: (1) an inquisitive stance that constantly affirms the value of mentalization by a respectful, curious and tentative inquiring attitude; (2) maintaining a balance between observing natural interactions and intervening to promote change by helping the family make sense of what feelings are experienced by each family member and highlighting ways in which miscommunication or misunderstanding (or lack of understanding) of these feelings leads to interactions that maintain family problems; (3) intervening to terminate non-mentalizing interactions and shift attention away from preferred non-mentalizing narratives ('non mentalizing fillers') to help create new and different perspectives highlighting the missing perspective for each person in the family that leads to the behaviour of others not being fully understood; (4) highlighting and reinforcing positive mentalizing, deepening people's ability to connect feelings, thoughts and intentions positively connoting good examples (or episodes) of mentalization, possibly enlarging on them and their implications.

Once a problematic interaction has been noticed and focused upon, the family are invited to find ways to name it. The therapist uses techniques of 'pause and review' to help the family to collaborate ('form a working party') to think about interactions, from a higher order perspective. The focus on the mental states that might underpin a specific piece of interaction serves the dual function of sharing and provoking curiosity amongst and between the family members and generating an attitude that learning about how others are thinking and feeling is potentially enlightening. Gradually, the family discourse is expected to shift away from discussing a specific interaction that occurred during the session and to 'widen the lens' to capture more generalised understandings relating to this specific observation. As part of this process the therapist may ask the family to generate possible applications of specific understandings gained, by inviting specific alternative strategies, and then planning the implementation of suggested changes. Reflecting on the process of engaging in a mentalizing approach is key to sustaining the process. Even if the meta-reflection is

seemingly negative, it can provide the basis for the next episode of non-mentalizing (i.e. trying to understand what might have gone wrong with the process of trying to understand each other which was just unsuccessfully undertaken).

The MBT-F manual (2010) includes a number of '*mentalizing activities*', depicted as games or tasks, that the family can undertake. The therapist can choose from these in relation to barriers to progress encountered in a treatment. The main function of these tasks is to be ice-breakers and create a gradual 'desensitization' to mentalizing in families where past experience has created an implicit concern or even a 'phobic avoidance' of the activity. They also have a potential skill-developing function, as well as the potential to generate relevant information (alternative perspectives) when the family appears stuck on a specific issue. The tasks can also help with the generalisation of learning as part of 'homework' – tasks the family can practice without the therapist. An example of a mentalizing task involves the inversion of roles. The child or adolescent is asked to identify a situation they find complex or conflict-ridden, and the parents are asked to adopt the child's persona in that situation (e.g. going to a school function, time to do chores, go to bed). The parent, in role-playing the child, has to imagine and report on what may be going on in the child's mind during the scenario while the child just listens to the parents struggling with the task. The child is encouraged to help the parents out, or consult to them, by telling them what to think, say, and feel. At some point the therapist encourages the parents and child(ren) to reflect on how they think/feel in both similar and different ways from what has been played.

In the '*feeling finder game*' family members are invited to create a story centred around experiencing feelings. At each significant moment in the story the person telling the story says "*and that made me feel...?*" The child then has to find the facial emotion or emotion word (as appropriate to the child's developmental level) that they think fits the situation. The person telling the



story then tells the child what he/she actually felt. Each time the child gives the same answer as the storyteller, the child moves one space on a 'snakes-and-ladders' type board. When the child does not give the same answer as the storyteller, the family or therapist help the child understand what the situation meant to the protagonist and what he/she thought.

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

At the core of this therapeutic approach, whether observing normal interaction or playing mentalizing games, lies the same deep commitment to help the family

make sense of what feelings are experienced by each family member, what thoughts are connected with these feelings, how these feelings are communicated within the family, and how miscommunication or misunderstanding (or lack of understanding) of these feelings can fuel interactions that maintain family problems.

### **Preliminary conclusions**

Work with emotions in the context of family therapy is gaining pace though is still not a frequent priority and often linked with psychoanalytic practices (Pocock 2009). The idea that a person's emotions are deeply influenced by the prevailing emotional system she finds herself a part of at any given moment (Bertrando & Arcelloni 2009), is perhaps not a novel one, but the increased emphasis on working with emotions in the 'here and now' is still fairly recent in the systemic field (see, for example, Fredman 2004, Kavner & McNab 2005, Pocock 2005, Dallos 2006). Various systemic practitioners have explored the therapeutic territory which transcends the seemingly clear distinctions between systemic, psychoanalytic and cognitive approaches and helpfully explored common ground (Larner 2000, Donovan 2009, Flaskas 2009). Do we need a new therapeutic approach? MBT-F has some distinctive features which are different from, but complementary to, the systemic approach. It is different from, but also has plenty in common with, other more recently emerging family therapy approaches which emphasise the importance of attachment theory (Akister & Reibstein, 2004; Byng-Hall, 1991; Dallos, 2006; Diamond & Siqueland, 1998), or which attempt to bridge the systemic and psychodynamic worlds (Flaskas, 2002; Fraenkel & Pinsof, 2001). An emphasis on mentalization does not radically alter the priorities of a systemic therapist, but it focuses on essential phenomena that might otherwise be marginalized. It can enhance the effectiveness of systemic therapy by providing a way to get around common blocks in therapy and making family members more receptive to tuning into each others' thought and feeling states. Above we have outlined some of the positions and strategies therapists

can adopt when using mentalizing in family therapy. The approach is not considered by any of us as a new form of therapy per se. If anything, it takes systemic approaches back to what is probably a core and common aspect of all psychotherapeutic work: the elaboration of subjective experience to facilitate interpersonal understanding. More specifically, at this time MBT-F perhaps provides an approach which bridges the often seemingly opposing 'internal' psychodynamic and 'external' systemic worlds. It does so by integrating important concepts from the fields of attachment theory and reflective function (Fonagy et al., 1991) with systemic approaches, and in this way MBT-F is itself an example of what 'good' mentalization can achieve in resolving apparently irreconcilable points of view.

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