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Mentalizing in Interpersonal Psychotherapy

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Abstract

Mentalization -- how we understand our own minds and those of others -- is an attachment-based normative cognitive and affective capacity central to mentalization-based therapies. Mentalization seems related to aspects of and may hold important potential implications for interpersonal psychotherapy (IPT). The IPT manual does not explicitly describe targeting improvement in mentalization but IPT may employ it as an underlying process. Recent mentalization theory emphasizes the applicability of a mentalization model to many if not all types of psychotherapy, and it may have particular value for affect-focused and socially focused psychotherapies like IPT despite its differences in focus and diagnostic targets from mentalization-based treatments. This article reviews the overlap of these approaches and suggests the potential that mentalization might mediate IPT outcome.

(122 words)

Introduction

Mentalizing is a cognitive and affective domain encompassing the capacity to understand that mental processes like thoughts, feelings, and wishes underlie one's own and other people's behavior. Bateman and Fonagy (1) describe it as "the process by which we make sense of each other and ourselves, implicitly and explicitly, in terms of subjective states and mental processes (p. 11)." Mentalizing is a basic human attachment-based capacity and a prerequisite for social interaction (2). Studies show that some forms of psychopathology permanently impair mentalizing ability, whereas in other disorders reduced mentalizing capacity may be situational and reflect emotional stress (3). This paper addresses whether improving mentalization might be a mechanism of change in Interpersonal Psychotherapy (IPT; 4), a short-term, manualized treatment originally developed to treat major depression. Many randomized trials have shown its efficacy (5,6). Research has shown IPT also benefits patients with eating disorders, PTSD (7), and other conditions (4,6).

Fonagy and colleagues have suggested that improving mentalizing capacity is a key change mechanism across psychological treatments (8,9). One study found that pre-treatment Reflective Functioning (RF), an operationalization of explicit mentalizing rated on the Adult Attachment Interview (10), influenced IPT improvement trajectories (11). Some trials suggest that improved RF might partly account for symptom reduction in some treatments (12), but others found no significant correlations between change in RF and symptoms, even though RF improved and symptoms decreased (11,13). Rudden et al. (13) found Panic-Specific RF improved in Panic Focused Psychodynamic Psychotherapy (PFPP), but not in Applied Relaxation Therapy, a cognitive-behavioral therapy (CBT) for panic. Similarly, Ekeblad et al. (14) found that IPT, but not CBT, improved RF rated on attachment history (AAI) for depressed patients. Rudden et al. (13) found symptom-specific RF, a measure of patients' ability to reflect on and mentalize the emotional meaning of their symptoms, but not standard RF, improved in PFPP. Different treatments, with sometimes different goals, probably change different aspects of RF to different degrees. The authors believe that RF may have particular importance for affect-focused therapies like psychodynamic psychotherapy and IPT, in contrast to more behavioral approaches; but this requires far more research.

Treatment principles in IPT

IPT was developed as a time-limited (usually 12-16 sessions in as many weeks), diagnosis-focused treatment based on attachment theory (14,15) and on understanding how life events and social support interact with mood and other psychiatric disorders. The IPT therapist defines the target diagnosis (e.g., major depression) as a treatable illness that is not the patient's fault. IPT helps patients to link their feelings and life circumstances. IPT therapists elicit and normalize emotions related to interpersonal encounters and help patients to verbalize them by communication analyses and in role play, priming patients to handle social relationships adaptively. This helps strengthen social support, imbues a sense of mastery of the social environment, and has been repeatedly shown to alleviate a range of psychiatric symptoms (5,6). While facilitating a strong treatment alliance, IPT focuses patients on life circumstances – resolution of an acute, depression-linked crisis such as a role dispute – rather than on the therapeutic relationship in the office; IPT does not interpret or work within the transference (14). IPT has targeted what DSM-III and DSM-IV termed Axis I disorders: excepting pilot work on borderline personality disorder (16), IPT has not been applied to treating personality disorders.

Without focusing on the therapeutic relationship, IPT nonetheless may improve patient mentalizing. IPT focuses on affects and emphasizes helping patients tolerate, modulate, and understand their emotions to address emotional and attachment aspects of interpersonal functioning. IPT empathically validates the patient's narrative, helps to identify and name affects, and provides clarification and exploration.

IPT focuses on the *content* of patient relationships, organizing cases around interpersonal themes (complicated bereavement, role dispute, role transition, or social isolation). This contrasts with treatments explicitly focused on improving mentalizing capacity. Mentalizing-based treatments first and foremost focus on helping patients to improve and stabilize their mentalizing capacity: they primarily focus on the *process of mentalizing*, on stimulating patient curiosity about problematic emotional responses. The therapist attempts to enhance the patient's mentalizing process, i.e., to create curiosity about alternative understandings of interactions, and to avert collapse of mentalizing, so-called “non-mentalizing” modes of experiencing oneself and others. When a patient loses mentalizing capacity, falling into psychic equivalence, pretend mode, or a teleological mode, the therapist works to reinstate mentalizing. The therapist adopts an inquisitive stance: acknowledging not knowing what the patient is thinking, and curiously

questioning the patient about thoughts and feelings (1). The IPT therapeutic stance, meanwhile, addresses helping the patient find ways to improve social functioning via understanding patient feelings in social encounters. Hence IPT, at least implicitly, focuses on mentalizing in inviting patients to reflect on their emotional understanding of interpersonal encounters and the role they play in them. A few teaching programs include mentalization as a topic in IPT training.

Purported change mechanisms in IPT

Knowledge of potential change mechanisms in IPT remains scarce. Its developers advocated a multifactorial perspective (1). Although a few empirical studies have reported associations linking change in interpersonal functioning and attachment security with change in depressive symptoms (17-19), they failed to show temporal mediation. Thus, changes in depressive symptoms could cause changes in relational problems or *vice versa*, or perhaps more probably, such improvements could continuously interact during the treatment course.

Lipsitz and Markowitz (20) hypothesized that enhancing capacity for emotional processing, increasing social support, decreasing social stress, and improving social skills might explain symptom improvement in IPT. These mechanisms might all result from improved mentalizing capacity, as mentalizing can be considered a general capacity to understand emotional and relational aspects of human interactions, and part of IPT process implicitly involves mentalizing.

Background of the concept of mentalizing

Mentalizing operationally derives from psychoanalytic theories (21). In 1934, Sterba (22) suggested that the therapeutic action of psychoanalysis lay in the patient's identification with the therapist's observing ego. He conceptualized the patient as entrenched in rigid self-conceptions, that analytic interpretations could unlock to permit wider, more constructive self-reflection. This observing stance may be particularly important in the patient's attempts to understand reactions to the therapist in the transference. Working to improve patient curiosity about how the patient's mind, and the minds of others, work can be considered a continuation of Sterba's speculations about identification with the therapist's observing and reflecting stance. Mentalizing treatments

aim to improve patient mentalization capacity in order to enable more constructive ways of learning from current social interactions outside therapy.

The communication model

Fonagy and colleagues (2,8) recently presented a new model for therapeutic change based on mentalizing in therapeutic interactions. This derives from experience in treating patients with BPD, but Fonagy et al. suggest the model applies to most psychological treatments. The model describes three “communication systems” that contribute to learning in psychotherapy. The gist is that helping the patient feel mirrored in a marked way activates the patient’s own mentalizing capacity. This emergence of the capacity for mentalizing typically first appears in relation to the therapist, as the patient develops greater interest and curiosity in the therapist’s mind.

The model’s first system involves the patient feeling understood (“mentalized”). An important aspect of this early therapeutic work is that the patient sees the therapist’s suggestions as ostensive cues, leading to a decrease in the patient’s epistemic hypervigilance (i.e., distrust in the particular model or approach the therapist presents), leading to emergence of the patient’s capacity for mentalizing. This activates a second communication system: the patient’s improved mentalizing capacities generate greater curiosity about the therapist’s ideas about how to understand the patient. This generates further epistemic trust, i.e., the patient’s capacity to accept knowledge that the therapist explicitly or implicitly presents as valid, applicable to the patient, and generalizable to other contexts.

This drives learning involving a third communication system. Re-emergence of epistemic trust and improved mentalizing capacities foster capacity for social learning or salutogenesis, the capacity to benefit from positive influences in one’s social environment.

In this view, improving mentalizing as such is not the therapeutic goal. Mentalizing is rather a precondition to increase openness to new social experiences. The ultimate goal of psychotherapy is to strengthen the patient’s ability to learn from new experiences.

Mentalizing as a potential mechanism of change in IPT

IPT focuses on helping patients create or renew social contacts and social support. The patient’s ability to understand the motives of significant others by recognizing and using the affects that arise in difficult situations and relationships, analyzing communication patterns, and

then role playing using this understanding, may benefit from and contribute to better mentalizing. Improving mentalizing capacity may thus be key to IPT therapeutic processes and might well mediate IPT outcome. The explicit focus on improving mentalizing central to mentalization-based interventions, is not, however, a stated goal in IPT.

IPT focuses on patient handling of affects and interpersonal conflicts in defined problems areas and relationships, tasks that require capacity to mentalize about others. Understanding how interpersonal functioning relates to mood and distressing life events that may have triggered a depressive episode again requires the capacity to mentalize about oneself. Mentalization is a crucial (unnamed) facet of IPT communication analysis (4): how the patient understands his or her emotional reactions to an interpersonal encounter outside the office, what that affective response reveals about the situation, understanding the other person's emotional reaction, and how the patient can use this understanding to improve social functioning in that relationship. Several mentalizing-informed techniques, such as the "contrary move" (23), e.g., from a cognitive to an affective focus or from self to other, and the therapist modeling mentalizing, are also used in IPT although with other descriptors.

Communication analyses and role playing, key IPT techniques in preparing for interpersonal encounters, constitute what Bateman and Fonagy term "controlled mentalizing: ...a serial and relatively slow process, which is typically verbal and demands reflection, attention, awareness, intention and effort" (24, p. 2895).

Interest in mentalizing in IPT grew while applying IPT to treatment of patients with chronic PTSD who, unlike most depressed patients, reported near or complete emotional detachment (25). Before they could engage in the basic IPT strategy of linking affect to situation, they needed affective reattunement to regain access to their feelings and what they meant (e.g., anger generally means you feel unfairly treated). The first half of the 14-week treatment was therefore devoted to building mentalizing capacity, without utilizing that term. Once patients could begin to read their emotions and those of others, IPT could proceed as usual.

The recent Fonagy et al. model of therapeutic change can be considered a "common factors" model insofar as it applies to most psychotherapies, irrespective of specific therapeutic interventions (26). Its basic principles are genuine therapist curiosity in understanding the patient's understanding of problems, and the therapist's presenting to the patient, using ostensive

cues, a comprehensive, comprehensible model of change. By demonstrating that the therapist has ideas about how the patient can ameliorate his or her situation, the therapist engenders the patient's epistemic trust. Belief in the therapist evokes trust in the patient's own capacity, gradually increasing patient sense of agency.

The IPT change model arguably fits this schema. A major step in IPT's initial phase involves helping the patient realize that he or she can actively change things to resolve a life crisis and reduce symptomatic suffering. The therapist may implicitly improve patient epistemic trust through therapeutic optimism, encouraging and helping the patient explore potential options. Diagnosis-derived rigidity in the patient's conceptions yield to more flexible understanding of social interaction. Improved epistemic trust, associated with better mentalizing capacity, opens the patient to new experiences in daily social interactions. Thus, although IPT guidelines and vocabulary do not mention mentalizing, the concept accords with IPT principles.

Case vignette

An example may help illustrate how mentalizing might promote change in IPT while indicating aspects of IPT that differ from the communication model.

John is a 24 year-old man with Major Depressive Disorder. In his teens he entered supportive psychotherapy for several months to treat a depressive episode. His mood improved, but the depression has recurred since. Recently he moved to a university city distant from his home. Soon after starting a technical program, he felt lonely and wanted to return home. His father, however, insisted that he stay at the university. After a few more weeks, he went home, nonetheless. After a harsh conflict with his father, John returned to school but stopped attending lectures and lay in bed for a week. A fellow student found him after he overdosed on painkillers in a suicide attempt. He was briefly admitted to a psychiatric ward. Interviews with the ward psychiatrist indicated that John had friends in his home town but had become isolated at university. The only child of two older parents, when young he had been close to and looked up to his father, but during adolescence he had turned to friends, distancing himself from him. John had had some short relationships with a few girls, but never established a stable romantic relationship.

After leaving the hospital and again returning home, he contacted a psychiatric service for depression treatment. John was offered a 12-session weekly course of individual IPT. After considering role transition (leaving home and developing an adult identity as a college student) as a problem area, John's therapist suggested a role dispute with his father as the acute interpersonal problem, as their conflict seemed central to his emotional upheaval. John agreed.

Therapist: How have things been since we last met?

John: Oh, not good. I'm really depressed being at home with my parents, and yesterday I had another fight with my father. He's pushing me to go back to the engineering program, and I'm thinking I need a gap year to take a course in poetry writing.

Therapist: Sorry to hear you had another fight. What happened?

John: It's always the same. We were talking about the flowers in the back garden, and then he begins to push me to go back to school to become a high paying engineer. He drives me crazy!

Therapist: So you were feeling –?

John: Angry! What do you think? I don't tell him what to do. I told him, "I'm not you, and I don't have to spend my life compensating for your disappointments!" Why does he have to try to run my life? To ruin my life?!

Therapist: Does it feel reasonable that you got angry when he tried that again?

John: Yes, sure! It just doesn't do any good, and afterwards I'm exhausted and more discouraged than ever. I feel helpless, everything feels hopeless.

Therapist: It does seem reasonable to feel angry when you feel treated unfairly. I also agree with you that your fights just sound exhausting. Like you're at an impasse. I'm wondering: what other options do you have for handling this exasperating situation with your Dad?

[Therapist first validates his anger, then invites John to consider alternative ways of expressing it, stimulating his curiosity.]

Having validated John's anger, the therapist helped him to explore options for handling his disagreement with his father more constructively. They then role played his confronting his father, evaluating both the content of what John wanted to say and his tone of voice. The therapist encouraged John to imagine how his father would react to different ways of expressing the anger.

[The therapist invites John to be curious about his father, a mentalizing approach.]

John considered several ways of expressing his anger and realized that none of them would seriously hurt his father. With practice, John was able to tell him: "Dad, I'd really like to have back the relationship we had before I left for college. I know you want the best for me, but you make me really angry when you try to dictate my life. Can we agree to disagree? If I do go into engineering, I want it to be because it's my choice; and if I don't, I hope you'll be proud of me as a poet." With some bumps, the relationship improved, as did John's mood.

This IPT case focused on renegotiating John's filial role dispute in order to improve communication and relieve depressive symptoms. John was well aware of his anger toward his father; in other instances, therapists must work harder to elicit patients' recognition and acceptance of their own feelings (27,28).

Although the description is short, we can attempt to understand this IPT treatment process through the mentalizing perspective of the communication systems model lens. The first goal would be to enhance John's trust in the therapist's attempts to understand him and his problem, and to present a useful change model. By acknowledging John's anger, and by exploring other ways to express it, although not being the explicit IPT intention, the therapist may have increased John's epistemic trust, and at same time improved his ability to mentalize his feelings. The ensuing role play intends to enhance John's expressing discontent and communication with his father. Implicitly, role play may have given John and the therapist opportunities to reflect on aspects of both sides of John's and his father's interaction. It might thus improve John's mentalizing about the dispute with his father. So armed, John later uses his

newfound mental flexibility to negotiate a better relationship with his father, an interpersonal encounter that may have helped improve mood and self-confidence (21).

It is important that patients cogently understand a specific treatment's rationale for why symptoms arise and how to address them. This accords with the communication systems model of a therapist presenting clear ideas of origins and treatments of the patient's problems while remaining simultaneously open to the patient's ideas and experiences. The classical IPT model focusing on identifying and solving an interpersonal problem has proved highly efficacious for several disorders. Unlike mentalizing treatments, IPT has no explicit intention to augment general mentalizing ability or improve patient social learning in general. As IPT does not directly target the therapist-patient relationship, altering IPT by adding an explicit mentalizing focus on therapist attempts to understand the patient's situation might well distract from the IPT therapeutic focus.

This has received too little study. Over more than forty years of clinical trials, IPT researchers have sought measures to capture aspects of how IPT works. The Social Adjustment Scale (29) measures social outcomes; interpersonal circumplex instruments (e.g., Inventory of Interpersonal Problems (30) assesses general interpersonal patterns; other scales measure perceived social support (31). None addresses the core interpersonal skill implicit in the IPT treatment process and in patient functioning in interpersonal encounters – which surely overlaps with mentalizing.

The Reflective Functioning Scale (RF; 32) may answer that need. A few IPT studies have used the general RF rated on life history (AAI), and symptom-specific RF (SSRF) measuring emotional understanding one's psychological symptoms. As IPT does not target life history issues, measuring current interpersonal problems may have greater relevance. Möller et al. (33) used RF ratings in studying prisoners' mentalizing about their crimes, and mothers' limit setting with their children (34). We are currently testing change in RF and SSRF as mediators of IPT outcome in PTSD (35). Further developing RF measures for specific symptoms, problems, and relationships might importantly advance understanding of how IPT attains success.

Conclusion

Although data remain lacking, improving patient mentalizing likely plays a key background role as a change mechanism in many psychotherapies, particularly affect-focused psychotherapies, including IPT. Improved mentalizing capacity has greater significance for patients whose mentalizing capacity is low. The communication systems model focusing on evoking epistemic trust in patients through therapist attempts to present a believable treatment idea fitting the patient's situation makes sense in IPT. This communication model is best seen as a common factors model, useful in most therapy methods, particularly those focusing on therapist stance and patient affect. The general significance of common factors, and particularly the mutual collaboration in the treatment alliance, has been shown repeatedly (36,37).

It is important to distinguish between the therapeutic interventions IPT uses to achieve changes and the idea that improved mentalizing might be an underlying change mechanism. The IPT manual does not describe enhancing the patient's mentalizing capacity (4). Therapeutic tools like role play and affect and communication analysis may well enhance patient mentalizing capacity. The general therapeutic stance Fonagy et al. (2,8) recommend to improve patient trust in the therapist – and in himself or herself – and to increase curiosity about social relationships accords with IPT principles. Thus, although mentalizing about both oneself and others may improve in IPT, the restoration of social communication, a primary goal in IPT, may in accordance with the communication systems model be a more important change mechanism.

Nonetheless, important intervention nuances between IPT and mentalizing-focused therapies deserve notice. In IPT, therapists openly validate patients' affective reactions, thereby strengthening their consciousness of (particularly negative) affects. Mentalizing-informed treatments tend rather to emphasize patients' curiosity about different emotional reactions. Another distinction is between the explicit IPT goal of resolving a particular conflict or problem, and the goal in mentalizing-oriented therapies of improving patients' general openness for learning from new social situations by better mentalizing. Therapist comprehension of different treatment conceptualizations and frameworks may enrich their background understanding of patients and may covertly benefit a course of therapy, but overtly employing multiple and competing frameworks as interventions has potential liabilities for the patient in encouraging eclecticism (38). Thus, IPT therapists should appreciate mentalization while continuing to follow the IPT manual guidelines (4).

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