Mentalizing, attachment and epistemic trust in group therapy

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Introduction

The theory of mentalizing, the capacity to understand ourselves and others in terms of intentional mental states (i.e. needs, desires, feelings, beliefs, goals and reasons), is embedded in attachment thinking. The theory proposes that in the course of normal development, mentalizing is first experienced and supported in the context of attachment relationships. Secure attachment relationships, in which caregivers are interested in and attribute agency to the infant's mind, create a safe environment in which the infant can start exploring other people's minds (Fonagy & Luyten, 2016). The capacity for balanced mentalizing first emerges in these early interactional experiences, in which the infant finds himself reasonably accurately represented by the other as an intentional being with separate thoughts and feelings (Fonagy, Gergely, Jurist, & Target, 2002).

Mentalizing and Epistemic Trust

The theory of mentalization has recently developed to consider another important function of attachment relationships, namely their role in the development of epistemic trust – that is, trust in the authenticity and personal relevance of interpersonally transmitted knowledge about how the social environment works and how best to navigate it (Fonagy & Allison, 2014) (Fonagy, Luyten, & Allison, 2015). Given the complexity of the human social and cultural environment, much of the information that juveniles are presented with is complicated and needs to be explained by an experienced elder. But it is not advisable to accept indiscriminately everything that we are told by anyone; some people might be unreliable informants, whether through ignorance or ill intention. It is appropriate, therefore, to hold a position of epistemic vigilance unless we are reassured otherwise. Csibra and Gergely have suggested that humans have evolved a species-specific social learning system – labeled natural pedagogy – to fast track knowledge transfer to conspecifics. Infants are sensitive to ostensive cues on the part of the communicator that signal the intention to

transmit new and relevant information to them (Csibra & Gergely, 2006, 2009, 2011). These cues include eye contact, turn-taking contingent reactivity, addressing by name and the use of a special tone of voice ('motherese'). These cues trigger a pedagogic stance on the part of the juvenile and primes them to consider the content being conveyed as relevant to them and thus should be incorporated as part of their general understanding of how their environment operates, i.e., it should be stored as part of their procedural and semantic memory rather than episodic memory. The use of ostensive cues in this way opens juveniles' epistemic trust, enabling them to accept that what they are being told matters to them, that it is part of their cultural currency that they can reapply and reuse. The transmission of knowledge via natural pedagogy first occurs, in normative human experience, in the context of attachment relationships. Secure attachment relationships – with their characteristic of contingent reactivity – by their very nature work to open epistemic trust. Accurate mentalizing, generally and powerfully, achieves the same end as, for example, looking at someone in the eye or calling them by name: it is an indicator of a recognition of agency and forms a powerful underpinning ostensive cue for the relaxation of epistemic vigilance within that relationship (Fonagy et al., 2015).

If an infant does not experience being adequately mentalized by her caregiver, her own emerging mentalizing capacity may become disrupted. But a further possible impact will be that – owing to the importance of mentalizing as an ostensive cue – the child's naturally occurring epistemic vigilance will not be replaced by the development of epistemic trust that opens the child to taking on the social knowledge that will guide her through the social environment (Fonagy & Luyten, 2016). We all seek social knowledge, but without the reassurance and support of trusted caregivers, family or peers, the content of communication can be confusing and it may be rejected due to perceived hostile intent. We suggest that many manifestations of mental disorder may be underpinned by an inability to benefit from social

communication due to epistemic mistrust or outright *epistemic freezing (petrification)*. The outcomes of these disruptions in epistemic trust can include a reluctance to modify beliefs and expectations, even in the face of social experiences that clearly indicate otherwise. Individuals who have experienced severe trauma and/or who are suffering from personality problems may be almost wholly unable to trust others as sources of knowledge about the social environment. An individual who has been maltreated, for example, may with some reason come to regard their caregivers as unreliable or mal-intentioned sources of information about the world, and as a result they may learn to reject communications from others that that are inconsistent with their pre-existing beliefs. This is an adaptive response to a hostile or threatening social environment, but in a clinical setting, such an individual may be considered "hard to reach."

Mentalizing – the Non-Mentalizing Modes

When mentalizing fails, individuals often fall back on non-mentalizing ways of behaving which have some parallels with the ways that young children behave before they have developed their full mentalizing capacities. The modes are: psychic equivalence, teleological, and pretend modes. These modes of experiencing the self and others particularly tend to re-emerge whenever we lose the ability to mentalize in a balanced manner (mostly typically for example, in high stress contexts).

In the *psychic equivalence mode*, thoughts and feelings become "too real," making it extremely difficult for the individual to consider alternative perspectives which may be applicable to the situation. In psychic equivalence, what is *thought or felt* is experienced as completely real and true, leading to a concreteness of thought. The *teleological mode* refers to states of mind where mental attitudes are only recognised if they are accompanied by a tangible signifier and lead to a definite outcome. Hence, the individual can recognize the existence and potential importance of states of mind, but this recognition is limited to very

concrete, observable situations. For example, affection may only be accepted as genuine if it is accompanied by a touch or caress. In *pretend mode,* thoughts and feelings are cut off from reality; in the extreme, this may lead to full dissociative experiences. Patients in pretend mode can discuss experiences in pseudo-psychological terms without contextualizing these through reference to the lived physical or material reality.

The Three Communication Systems in Group Work

Our recent work on the process behind effective therapeutic principles has set out three processes that facilitate the development of epistemic trust and the capacity to mentalize – which we label communication systems. These systems underpin change in the course of psychosocial treatment (Fonagy & Luyten, 2016).

- *Communication System 1: The teaching and learning of content that lowers epistemic vigilance*

  All evidence-based therapeutic modalities belong to this system. They have in common the therapist's ability to convey to patients a model for understanding their experience, which then enables the patients to convincingly recognize their own mental states. This may be achieved by the therapist providing explanations, offering useful strategies, suggesting interpretations or by just responding with high non-verbal contingency – or indeed any combination of these. This process of ostensive cueing, of 'teaching' and receiving new content in a way that demonstrates a recognition of the patient's agency and lowers the patient's epistemic vigilance.

- *Communication System 2: The re-emergence of robust mentalizing*

  When the patient is once again open to social communication in contexts that had previously been marred by extreme caution or epistemic hypervigilance, he/she shows increased interest in the therapist's mind and the therapist's use of thoughts and feelings. This newfound awareness stimulates and strengthens the patient's

mentalizing process. Improvements in mentalizing or social cognition may thus be a common factor across different interventions. Mentalizing demands collaboration (two minds working together), seeing things from the each other's perspective, treating the other as a person with a mind, recognizing them as an agent and assuming they have things to teach you, since mental states are opaque. The consistent mentalizing of the patient by the therapist continues to generate an experience of being recognized as an agent in the patient. This is also achieved by the consistent marking of the patient's experiences, and acknowledging the patient's emotional state. Such ostensive cues serve to denote the personal relevance of the transmission and its social value (generalizability). By mentalizing the patient effectively, the therapist models mentalization, creating an open and trustworthy environment against a background of low arousal which opens the channel for learning. Improving mentalizing is a goal of therapy, but primarily in so far as it enables the patient to learn from their wider social context, which takes us to the next Communication System.

- *Communication System 3: The re-emergence of social learning*
The relaxation of the patient's hypervigilance via the first two systems of communication enables the patient to become receptive to social learning. This allows the patient to apply his/her new mentalizing and communicative capabilities across all areas of his/her social life. The greatest benefit from a therapeutic relationship comes from generalizing epistemic trust beyond therapy so that the patient can continue to learn and grow from other relationships. This final part of this process takes place beyond the therapeutic relationship and is contingent upon the patient having a sufficiently supportive social environment to sustain their mentalization, and which continues to facilitate relaxation of epistemic mistrust in the wider social world.

Improved epistemic trust and the abandonment of rigidity enable learning from experience. This is a more systemic slant on what makes treatment effective, and it posits that the real change arising from effective treatment is a process that takes place outside of the treatment and involves a range of social relations.

These three communication systems can be understood in relation to group therapy. Group work provides an intermediate step, we suggest, in rehearsing mentalizing in more complex environments and in applying the social learning of therapy beyond the immediate therapeutic relationship. Mentalizing in groups can be challenging, with the range of possible interactions that take place inevitably being more varied and unpredictable than within individual therapy. The group can work as a 'training-ground' for developing and supporting the use of balanced mentalizing. It provides a regulated and safe social environment in which this learning can be practised and feedback can be given. By observing other group members' mentalizing imbalances, corrections and its benefits, social learning is reinforced and supported.

Critically, this mentalizing training-ground also creates an environment that encourages the appropriate opening of epistemic trust in the therapist and the other group members so that social learning can take place. Individuals with entrenched mental health difficulties – for example individuals with BPD, for whom mentalizing therapy was initially developed – tend to begin with particularly low levels of epistemic trust. The achievement of a group climate that promotes epistemic trust requires careful management of the format, structure, and pace of the group by the leader.

The Format and Structure of the Group

Introductory phase

A key component of the assessment process for a new patient is the identification and discussion between patient and therapist of recurrent patterns of relationships. The leaders actively prepare members for the group by assessing their capacity to mentalize, regulate emotions, and engage in interpersonal process. The patient's relational processes, which in effect reflect their attachment style, need to be recognized and agreed upon in the assessment discussion so that they can then be identified as they manifest in treatment. The leader explains the attachment style during the pre-group preparation so that the patient knows how the group will be useful to him or her. When joining the group, the patient will be asked to introduce himself and explain some of the difficulties that have led him to come to the group; the leader may help to further outline the difficulties during the initial session. An emphasis on attachment patterns is then consistently maintained in MBT – this is done collaboratively and explicitly with the patient – so that the patient is aware of their salience in the therapist's mind across the treatment process. In order for this to work, the patterns expressed in the initial formulation need to have been actively accepted in a way that involves a recognition of the agentiveness and subjectivity of the patient.

If the group is to function as a training-ground for interpersonal mentalizing, with the primary aim of facilitating mentalizing process between all group members, this can only occur if Communication System 1 is established. This is achieved by therapist conveying to the patient a model of the mind and an understanding of their disorder that feels accurate and credible enough for the patient to feel recognized and understood. For this model to be persuasive, the therapist needs to establish a group climate that is sufficiently containing, directive and empathic.

The Organization of Group Sessions

MBT groups take place weekly and each meeting lasts 75 minutes. There are six to nine clients in a group, and one or two therapists. There is no set preference for the presence of one or two therapists; it is generally assumed that two therapists may be advisable if the group is characterised by high levels of comorbidity, and there is a high likelihood of self-destructive behaviors. Each group session roughly follows the same trajectory, managed by the therapist to avoid the collapse of the group into a non-mentalizing process.

Sessions

Each session begins with a summary of the previous week's meeting. This involves a brief statement of the main themes raised and discussed, the therapist's perspective on these, and an acknowledgement of any issues that came up but were not resolved. If there are two therapists in the group, they will have agreed the outline of this summary at their post-group meeting a week earlier. The first part of the summary is mainly concerned with content, but these second part has a stronger emphasis on any problems that arose within the group – for instance difficulties or conflict that may have arisen between two of the clients.

> *'Last week we were discussing the difficulties that everyone has in recognising when someone may be trying to help. James brought up the example that he had reacted badly to someone who offered to help him complete an application form for the housing department. He thought it was demeaning and humiliating when it seems that the person was only trying to be helpful. Other examples were given of misunderstandings about other people's motives. We also talked about the difficulty of listening to each other here without being a suspicious of why someone is saying what they say. Angela thought that the comment by Phil about her drinking was a criticism and feels that people do not understand how hard she tries to stop drinking. I think*

those were the main points. Does anyone have anything else? Perhaps we can keep

the theme in our minds as we go around today.'

The purpose of this initial summary is to support the continuity of mentalizing across time, to help encourage the cohesion of the group by referencing previous experiences together, to orient patients to the themes in cases of erratic attendance and to organize the therapist's own mind. Once the leader has completed the summary, the leader can ask the group members whether they agree that this is accurate, and whether they would like to add anything. Over time it may become possible for group members to provide the summary.

'Go-around' of Problems

The next stage of the session is the go-around, in which the therapist asks group members if there is something they would like to raise or get help with in that particular session. The leader manages the process of 'go-around' by clarifying the problem (or problems) raised by the group member and then moving onto the next member, without stopping and exploring the difficulty. Other clients do not comment upon the other group members' problems at this point either. This process of managing the go-around in this way allows the therapist to maintain some authority over the process, and to allow the process of raising and discussing difficulties in a gradual and contained way, rather than explosively or very rapidly, potentially leading the group very quickly into non-mentalizing modes. It also serves to keep the group focused, which is made further possible if the therapist finishes the go-around with a short summary of the problems and themes raised by the patients. It further encourages the patients to listen to each other. If the process works smoothly, the go-around sets a mentalizing climate for the group at the outset of the session. However, the go-around can be a difficult process to contain. It can easily become over-long, and the therapist can easily lose the capacity to manage and contain each individual's response, so that there is no

time for the task to be properly completed. It is important to keep the process time-limited and not to become diverted by the events recounted by the clients: the emphasis for the therapist should remain on the mentalizing processes.

Synthesis of Problems

Again, this is a stage that is led by the group leader. Many of the problems brought to the group may be similar or have overlapping elements – for example, they might involve patients reporting self-harm, or becoming very angry or dysregulated, or having had fights. The synthesis approach can be particularly useful if too many problems have been raised and time-constraints make it difficult for the group to focus on each one individually. Synthesising in this way is also a powerful mentalizing process: it increases sharing of personal problems between participants, increases affiliative processes and maintains the authority of the therapist over the group process.

Focus of the Group

Often the particularly manifest distress of a member directs how the next stage of the group begins, which will also be recognised by the other members of the group. On other occasions, it will be less obvious who to begin with, in which case the therapist will start by asking one of the clients to explore more fully the problem he/she raised in the go-around. Some therapists suggest that a set time is allocated to each problem; this is known as 'turn-taking' and ensures time is shared fairly. This technique needs to be used cautiously, however, as there is a risk that it may encourage non-mentalizing by stimulating teleological processes within the group – *'I must have my 10 minutes even if I have nothing to talk about. Otherwise I will feel that no one is interested in me and I am not wanted in the group'*. It can also undermine the normal social interactive process of moving around and across topics, and does not lend itself to the linking of problems, so that one person's difficulties can help to inform another's dilemma. Overall therefore, excessive structure can undercut the

mentalizing process. A further risk is that it may result in individual therapy within the group, with the group working with one individual and focusing on the content of his/her problem at the expense of interactive mentalizing.

If a synthesis of some of the problems has been agreed, these synthesised experiences become the focus for the group's discussion. Once some of this group work is underway, the leader can consider guiding the discussion to consider what is currently going on in the group that might be similar or relevant to the problem. This makes the discussion immediate and aids learning about how emotions can be expressed constructively in a relationship. Across this discussion, the therapist also continually works towards mentalizing the relationships in the group through the clear identification of the affect when necessary.

Close of Group

The therapist needs to indicate to the group that the session is coming to an end while leaving enough time for important topics to be 'closed' safely. One way of achieving this is for the therapist to summarise the work the group has done so far and mention ongoing problems, asking the patients to focus on these areas for the remaining time. This also allows the therapist to emphasize important learning points and areas to be addressed later.

After the Group: Mentalizing about Mentalizing

Following the group, the leader or co-leaders consider their experience of the session and may wish to talk to another therapist if they are facing a serious clinical problem and need advice. This discussion may focus on a number of areas such as the absence of some group members and the overall process of the group – did mentalizing take place, and who participated in this? Were there any persistent indicators of non-mentalizing and are any patients more identified with non-mentalizing process? Risk issues and how to address them will be discussed.

The Leader's Stance

The MBT approach to group work places many demands on the leader. In order to capture what we are asking therapists to do in terms of maintaining the flow and structure of the session, we have described the mentalizing leader's stance to promote communication system 2. The salient elements of this stance are:

- Maintaining authority without being authoritarian

- Maintaining leader's mentalizing

- Maintaining focus and not allowing persistent non-mentalizing dialogue

- Monitoring arousal levels and non-mentalizing modes, in particular being aware of the hypermentalizing

- Working in current mental reality as much as possible

- Modelling mentalizing.

The characteristics of the leader's stance in MBT, therefore, present certain differences to other forms of interpersonal focus groups. For example, no interpretations are made about unconscious processes and similarly leaders refrain from making interpretations about the group as a whole. The leader is an active participant in the group, rather than adopting a position that is secondary or 'meta' to group processes. However, while it is active, the leader's stance is also one of 'not-knowing' – the leader models a relational curiosity rather than elaborating complex relational hypotheses. In doing this, the leader models his/her own mentalizing, demonstrating his/her thinking as explicit, transparent and understandable.

The leader maintains authority in the group by, in the first instance, openly and repeatedly explaining the group's primary task. Within each session, this involves maintaining the structure of the group's session and stating its principles. The leader also maintains authority through an active and participating approach, rather than being an

observer in the group. The not-knowing stance, rather than appearing as an absence of authority, needs to be combined with a highly attentive and observant stance, which can involve taking control of the trajectory of the group's discussion when necessary. This may involve using the 'stop,' 'rewind ' and 'explore' technique when non-mentalizing modes start to arise – to bring the conversation back to the point at which mentalizing started to break down and make sense of the mental states that were dominating at that point. The therapist also notes and praises mentalizing when it takes place, and maintains it for the group. The content of the group is not given free rein, and the therapist frequently returns to the topic or interaction under discussion.

The leader actively monitors the anxiety levels of the whole group and of each individual in the group to ensure they do not become either too high or too low. Over-arousal results in the group or an individual becoming uncontrolled, while inadequate expression of emotion and over-intellectual discussion – especially hypermentalizing – prevents the development of mentalizing in the context of 'hot' attachment interactions. Both situations are to be avoided, and it is to this end that the leader maintains control of the group. The leader needs to be attentive to all members of the group, not just the individual who is currently talking. It is particularly important to be alert to concurrent activity in the group, which may indicate an emotional response has been elicited. It may be useful to put the current group discussion 'on hold' while this concurrent activity is attended to and in some way resolved.

Key to the group work and critical to the constructive development of the group are interventions that aim to increase mentalizing within the group in the immediacy of the moment. But while we stress that most of the work focuses on the current mental reality, this does not mean that there should be no consideration of the past and future, both of which may

be a part of current reality as a patient explores his/her own meaning and considers him/herself in future situations.

Finally, the leader's own mentalizing is important as it serves as a model, and can serve to prevent the interactional escalation of non-mentalizing interactions. Identification by the patients with a leader and with the therapeutic process is an important aspect of all therapy. The leader overtly engages in mentalizing processes, openly asks him/herself questions, actively takes a not-knowing stance, authentically listens and takes an interest, and shows that his/her mind can change. If two therapists are in the group they talk to each other, in turn elaborating or questioning what the other says, and even challenging each other. This models mentalizing as an interactive process and shows that disagreement can help generate a better understanding.

Using the Group as a Mentalizing Training-Ground

We have set out how sessions are structured in mentalizing group work and explained the leader's stance. Here will explain how in the body of the sessions, the work undertaken seeks to function as a mentalizing training-ground and how it fosters epistemic trust in group members, which enables them to learn from and apply the mentalizing processes experienced in the group to the wider social context.

It is the authenticity of the leader's curiosity – which generates a mentalizing attitude towards personal problems and establishes a culture of enquiry – that is the key to making possible the relaxation of epistemic mistrust. The 'culture of enquiry' is not simply an interest in what happened during important events in the patients' lives. It is more about the underlying motivations, that is, what makes someone do something or say something. It is about becoming aware of what feelings and thoughts contribute to decisions and choices; about respecting others' ideas and allowing them to hold a different perspective; about minds changing minds. To reach this laudable aim of creating a culture of enquiry, the leader must

not only promote mentalizing in the group but also tackle non-mentalizing quickly. He/she needs to be alert to the common indicators of non-mentalizing – dismissive statements, use of stereotypes, generalizations, absence of curiosity, over-inclusive talk, excessive detail about events, behavioural change, and so on. Equally, the patients need to be aware of non-mentalizing process in themselves and others. The ways in which this mentalizing work can be achieved will now be broken down into certain practices and techniques.

Clarification

A form of non-mentalizing that groups have a frequently observed tendency to fall into is hypermentalizing, in which groups get stuck in pretend mode. This can be a difficult situation for the group leader to act on, because the tone and content of the conversation so closely appears to be working in the way that the group leader has indicated. One of the techniques used to rebalance the mentalizing of the group is the 'go-around structure' which serves to prevent the groups falling into lengthy pretend mode silos in which members might appear to be engaging in an issue but avoiding authentic mentalizing around in the context of attachment issues. An example of this kind of scenario is captured by the 'dead cat process' (Bateman & Fonagy, 2016) following a discussion in a group about the death of a cat. In summary, this is a situation in which all the patients describe a similar story. This has the appearance of an interpersonal dialogue but in reality each patient is in a 'silo' and speaking only from their perspective, with no real engagement with the mental states and experience of the others.

> **Phil:** *I am really busy and spend all my time doing things for my family. They rely on me to do stuff for them. They say that I have time because I am not working and so can do the shopping, cleaning, cooking. I am a housemaid being used by them.*
> **Sharon:** *I know what it is like to be used. I had a job and my boss got me to do everything that no one else would do. I cleaned the toilets, emptied the rubbish and I*

was supposed to be employed to do the packing of the toys that were ordered. Shit. So I told them where to stick the job and left. Never let anyone tell you what to do.

James: *I have never let anyone tell me what to do. People used to try when I was at school. I sorted them out. Walked off or smacked them up depending on who it was. No one tells me what to do. They just want to control you. Most of them get pleasure out of it. Like the prison officers who think that they are superior. They walk around in their uniforms feeling important. I made sure that I got them in trouble.*

Each patient continued to relate their own stories of being told what to do by others. Each patient remains focused on him/herself, with little turn-taking in the interaction. It is as if they all want to tell their own story without concern or interest in the others. It is the task of the MBT therapist to prevent this kind of collapse into self-orientated, hypermentalizing silos.

Clarification of self and other states of mind is one of the strategies the therapist can use in response to the tendency of individual group members to fall into conversational silos that are highly self-orientated and which, despite their apparent emotional frankness and content, involve little balanced mentalizing in terms of self and other, or affect and cognition. Such tracks can be highly appealing conversationally and hard to 'break' owing to their emotional intensity and their self-disclosing quality.

There are two forms of clarification that the therapist can use in these circumstances. In the first instance, the therapist attempts to establish a *clarification of events*. This involves establishing the sequence of what actually happened: what was the build-up, who was involved, how did the interaction develop, how did the patient respond? Some patients will respond to this by recounting events in unnecessary detail, giving elaborate accounts of interactions and the complicated motivations surrounding them – this can indicate slipping into pretend mode, or hypermentalizing. This non-mentalizing mode is often adopted to

counter feelings of anxiety, and it can become highly circular and non-productive. It is important, if possible, for the leader to be active in asking for a 'cut-down version' when this process of clarifying events becomes submerged by a hypermentalizing account. Accordingly, the therapist might say,

'I don't mean to cut you off but I think the story is becoming clearer. It sounds like you are all talking about feeling controlled by other people who try to tell you what to do and at times you find yourself doing it but resenting it. Is this what we are talking about? Could you just give us the main points so that we can start to think about the important areas with you? What are you missing out on in being told what to do?'

Mentalizing In the Group

Once the sequence of events is clarified in this way and the 'silos' have been joined to some extent, the therapist can then take the minds of the group members, asking them to think about what they have heard. Mentalizing the problem brought to the group is one of the core tasks of group work. With the direction of the leader, the group members are asked to what we call 'micro-slice' the situation: to articulate the mental experiences of the patient concerned as the event described took place and also to articulate their own thoughts and feelings about the problem. This process will often require the leader to probe members the group about their responses to what they have just heard. In the example above Phil began to describe how he felt weak and lacking in manliness that he was having to do house chores. So he was struggling with a sense of autonomy and identity feeling forced to be someone he did not like. He felt stuck in this position and unable to find a way out.

Some group members will have already indicated their response to the story that has been told, in which case the task of the leader may be to ask them to elaborate on their reactions. For example, quite typically one or more group members will have rapidly shown support for and identification with the index patient's problem. Or another patient may take

an oppositional stance, disputing the index patient's account or interpretation. Whether manifesting as an alliance or opposition, the responses of the other group members need to be considered by the therapist in terms of their mentalizing style.

There are several possible dangers that the group leader(s) needs to be highly attuned to when working at mentalizing a problem with the group. The first is the risk of becoming stuck in a form of individual therapy, in which the serious issue raised by a particular group member comes to dominate the session – one method of responding to this is using the triangulation technique, which we will discuss in more detail below. The second pitfall is that the therapist can easily become distracted by the need to make sense of the problem, to get to the bottom of mentalizing the scenario on behalf of the group, and then explain it to the group. This is a natural response to the confusion that often seems to dominate group work: the urge is for the therapist to use their mentalizing capacity to do the mentalizing for the group, and then lay it out before them. However, this is counter to the purpose of the group, which is encourage the active mentalizing processes of the group members. The third pitfall is that the group can become dominated by highly rapid interaction, which becomes unreflective in character. Such rapid and intense interaction can appear misleadingly interpersonal in character, but it can be rather superficial and based on implicit assumptions rather than balanced mentalizing. In this situation, it is important for the leader to maintain control of the situation by slowing, stopping and rewinding the conversation to the point at which mentalizing broke down.

Identification of Members' Relational Patterns Enacted in the Group

The following case study demonstrates how relational patterns are used in the group. Rebecca was a 26-year-old woman who reported many relationships in which she was violently abused at times. She was self-destructive, using self-harm as a way of managing emotional turmoil. She was easily led by others. She was dependent on her boyfriend and

recently had engaged in group sex, at his request. When asked what had made her agree, she stated that 'I had to do it to try to keep him. Otherwise he won't love me and will leave me.' Her tendency to defer to others and to try to please them was one focus of the assessment and was identified as a pattern that was recognisable over time and present in a wide range of situations. With regards to her insecure attachment style, she would be considered preoccupied given her focus on others while devaluing herself. It was incorporated into her formulation, with the leader wondering if she relied on others because she was uncertain of her own mind.

Rebecca attended group sessions regularly, always arriving on time. Most sessions started with her telling the therapist and other group members that she did not have anything important to talk about. Nevertheless, a topic for her would be agreed after a discussion that had all the appearances of being a joint process. Despite the joint process, the sessions seemed to make little progress in developing the areas she had identified as important to her, and there was no change in terms of Rebecca feeling better about herself, reducing her self-harm, or reflecting on her relationships, all of which were topics that had stated were important. During one group session, the focus was on Rebecca's concerns that she had had an argument with her boyfriend, and it was her fault. She realised that she had upset him by saying the wrong things.

> *Rebecca: It was me. I should never have said to him that I did not want to go with him to the dog races. He told me that I had to go because his mate was bringing his girlfriend and he wanted his girlfriend there. I don't know what made me say it as I probably wanted to go really.*
>
> *Therapist: What makes you say you wanted to go?*
>
> *Rebecca: I wanted to go for him.*
>
> *Group member: you should stand up for yourself and not give in to him.*

Rebecca: You are right. I know that. But I want to do what is best for him.

Other group member: What about you?

Rebecca: I am important too as you say. I think you are right as well about that.

This conversation continued with other members of the group urging Rebecca to stop doing things simply because her boyfriend wanted them. Gradually, it became apparent that Rebecca was agreeing with everything that was being said to her in the group – 'you are right'; 'I appreciate what you are saying'. But it occurred to the leader that the agreements were disingenuous, serving primarily to disarm the other members of the group through acquiescence. The group continually gave her advice about standing up for herself and urged her to do what she wanted. She was currently deferring to people in the group by agreeing with whatever was said even though none of it matched her internal state of being unable to assert herself. Her need to be liked dominated. She was unable to let the group know that their suggestions were unhelpful. She quickly thanked the group for helping her and suggested that the group move on to talk about more important things. Importantly, no one asked about her sudden rejection of her reflexive wish to defer to her boyfriend which may have been a momentary positive sign of standing up for herself. The therapist initially used a clarification:

Leader: Rebecca – can you take us back to when your boyfriend asked you to go to the races. How did you manage to say 'no' you did not want to go?

Rebecca: It just came out.

Leader: Rebecca I have a hunch about all this: are you agreeing with people in the group because you are not sure really why you initially challenged your boyfriend? You now dismiss it as being wrong. Yet you say the group are right that you should stand up for yourself?

Rebecca: yes. I have no idea why I did but I know it was wrong because he then did not like me and got angry. But I think other people's problems are more important so we should move on now.

Leader: My hunch goes a bit further though. You just agreed with people and then want to move on, putting yourself down at the same time. Isn't this the very thing we are trying to help you with? Take your own time in the group and don't give it over to everyone else. Have your own opinion. What about exploring what allowed you to say 'no' to your boyfriend and what has made you now want to hand over the focus from you to someone else in the group?

Rebecca: I am not sure. I am not sure I want to take more time.

The therapist is attempting to focus on the pattern of relationships that Rebecca identified during the assessment and formulation and how they are playing out in the group itself. As previously mentioned, for each patient in the group the patterns likely to be activated during relational interaction in the group are identified prior to them joining. The leader is then sensitised to the reactions of the patients to Rebecca, for example, to see if their response, for some of them constant advice giving, is part of their own pattern. This too can be explored.

Mentalizing Interpersonal Process in the Group

In MBT group work, it is important to draw a clear distinction between interventions that work on interpersonal interactions within the group and interventions that focus on mentalizing the relationship. Interpersonal work explores the processes taking place between people rather than focusing on the mind itself. The two processes interact with each other and the therapist can move between the two layers of process, for example by focusing on a client's relationship pattern as it manifests itself within the group, but taking on a more

mentalizing stance towards a particular interaction at a later point. Interpersonal work focuses on the individual's family relationships, friendship patterns, work interactions and community relations, and how they impinge on the patient's life, both constructively and destructively. It is about how the patient brings these patterns and the underlying attachment patterns into the group itself. So, working on mentalizing interpersonal processes as they are demonstrated in the group takes the manifest aspects of the patient's relationships and looks at how they help or hinder the patient or are harnessed to give support in times of crisis. Only once the interpersonal patterns have been clarified is it possible to work in greater depth by mentalizing the relationship, taking into account developmental components.

In order to achieve a mentalizing exploration of the interpersonal interaction between patients, the leader needs to:

- Keep in mind the interpersonal network of each patient

- Identify patterns in external relationships that are repeated within the group; this should have been considered in the original formulation

- Balance exploration of relationships between the members of the group with consideration of their relationships outside treatment

- Explore the satisfying and dissatisfying aspects of relationships, both within the group and outside

- Link the patients' experience in the group to their relationships outside it.

Triangulation

Triangulation is a form of technical intervention often actively used by therapists in mentalizing group work. Making the decision to intervene in a dialogue between two people by introducing a third in this way requires sensitive judgment on the part of the therapist. Involving others in an intimate conversation between two group members too early can be disruptive; too late and the potential for increasingly detailed perspectives and understanding

is lost because the minds of the other patients are no longer attending to the issue under scrutiny. The purpose of triangulation is normally to address the collapse of self–other interaction into self–self interaction. When interaction between two patients, or between a therapist and patient, becomes inaccessible to the rest of the group, the isolation of the interaction from the rest of the group suggests that mentalizing has begun to shift from self–other to self–self, to the extent that the two protagonists are creating a shared representation which excludes alternative scrutiny. Often this is a collusion of sameness and agreement – *'I am just the same. I know exactly how you feel. You are right and no one should think differently.'*

By directing the discussion towards an individual in this way, the interactive process I encourage and it helps prevent the group from falling into an unhelpful silence. Putting the question to the whole group might allow some members to avoid commenting and to remain detached. With such issues in mind, the therapist might direct the discussion towards someone might have an interest in the problem or might recognize the difficulties the other person is presenting. The therapist has two possible ways of proceeding: he/she could ask the third person for their thoughts on the conversation taking place between the two other patients – *'What is your view about their discussion?'*; *'Can you help them with this problem?'* Or he/she could suggest that the person relates their own experience in relation to the dialogue – *'What is your feeling in listening to this?'*; *'What does it make you think about in yourself?'*; *'Does it trigger any ideas about your own life?'*

The difference in approach between these two methods of triangulation lies in whether the intervention becomes focused on the mind states of the other protagonists or on the state of mind and reactions of the third person – 'about them' or 'about me in response to them'. Encouraging another patient to consider the effect on him/herself of the discussion can inspire more interactive mentalizing, but this is not necessarily a guaranteed outcome, and the

therapist try to stimulate mentalizing further by moving the focus between the third person and the original discussants, while monitoring the outcome on interactional mentalizing.

Parking

Difficulties in relation to maintaining attentional control frequent manifest in individuals with BPD and other personality disorders. They may not find it easy to focus on a topic of significance to someone else if they are experiencing a powerful desire to talk about something affecting them. Attempts to resist the urge to disrupt someone else's discourse in this way may cause them increasing tension or even desperation, until it is simply impossible not to break in. But meaningful and creative interaction with others is dependent on good attentional control – at times we all need to overcome a strong wish to talk about something if there is a need to discuss something else or if we are to focus on another person. If people with BPD are to improve their personal relationships it is important that they increase their capacity for attentional control because this is the 'bread and butter' of the to-and-fro of conversations. They need to learn to inhibit their impulse to demand attention or, alternatively, gradually but sensitively divert attention to themselves in a socially constructive way.

The aim of the therapist 'parking' a patient is to help them generate this capacity, facilitated by the use of a positive therapeutic alliance. MBT therapists constantly monitor the arousal levels of all patients, following the MBT principle that arousal has to be maintained within a moderate range, neither too high nor too low, if mentalizing is to be facilitated rather than impeded. The therapist is constantly alert to indicators or arousal, whether behavioural or psychological. As soon as the therapist recognizes that a patient is becoming agitated, parking him/her may become necessary if the group process is not to be suddenly disrupted by that one patient's excessive anxiety. The patient may show his/her agitation by shaking a foot, moving around excessively or trying to interrupt; alternatively, he/she may be

withdrawn, looking down, furtively glancing or appear preoccupied. The therapist quietly notes this and asks the patient if he/she can wait for a short time so that the group can conclude the current focus before attending to him/her. Often, this is best done slightly conspiratorially as this will make the patient feel special and attended to by the therapist. But, equally, it can be stated openly – *'Rachel, can you hang on a short time so that we can finish off this with Phil. We will be back to you in a minute'*. The point here is that the patient must feel they are seen as a person with a need and that their urgent demand has been recognized. This allows them to temporarily inhibit the urge to talk about their own problem and possibly attend briefly to the problem being discussed.

The skill of the therapist is to know how long a patient can be 'parked' or placed in the queue. If it becomes necessary to allow a patient to take over the focus of the group, to 'un-park' him/her, the therapist needs to state this explicitly and to 'park' the active patient and his/her current topic for a time – *'Mark, can you hang on to that for the moment so that we can come back to it. I think Emma needs to come in now and talk about her problems as she can't concentrate on your issues at the moment. We will definitely come back to yours though.'*

Parking is a further way in which the therapist takes some authority in the group by working to ensure that arousal levels and patient needs are recognized and managed. The appropriately 'parked' patient feels that they are recognized as an agent and that their needs are identified. In this way, parking serves as an ostensive cue which signals to the patient that the therapist has a communicative intention addressed to his/her needs but asks that he/she waits for a short time while other concerns are dealt with. This encourages the patient to manage his/her internal pressure to dominate the discourse and to make demands on others. It is of course essential for the therapist to keep track of who has been parked and to return to their concerns sensitively when possible.

Siding

At some points in may be necessary for the therapist to actively take the side of a particularly patient in the course of group work. This is known as 'siding'. It involves more than merely being supportive to a patient: the therapist is in fact required to act as the mind of a vulnerable patient during an interaction. A therapist will need to begin to take sides is when it is clear that one patient is becoming increasingly vulnerable in the context of a discourse either between him/her and another patient or the rest of the group. A patient may (perhaps unintentionally) be cruel to another, or be dismissive remark when a patient is struggling to talk about a problem, or actively attack someone in the group verbally. At such a moment, the therapist needs to quickly assess the state of mind of the most vulnerable patient and takes some authority by siding with him/her. This is achieved by making a response on behalf of the vulnerable patient – *'That was a bit harsh, Karen. Can you try to express what you mean a bit differently?'* The therapist continues to act on behalf of the vulnerable patient in this way for as long as necessary while also ensuring that the other patient does not become vulnerable or feel under attack him/herself. The purpose of siding is to maintain reasonable levels of attachment arousal and to regulate immediate affect levels.

Summary

As the mentalization model has evolved, the social context of mentalizing has assumed increasing theoretical and clinical importance. We had noticed the remarkable beneficial effects of the social process entailed in group psychotherapy alongside the importance of structuring the group to enable interpersonal interactions to be protected to enhance the beneficial effects of social relationships whilst minimizing complications and interpersonal adversity. The theoretical framework that brings the group process to the foreground, outlined in the current paper, places primary emphasis on the acquisition of knowledge gained through social interaction, the opportunities for learning about oneself and

about others that relationships offer. In this context, the mentalization-based group is seen as being as therapeutic not simply because of the opportunity it gives to model more appropriate social behaviour, or indeed from the disclosures and contents of discussions that broaden an individual's experience of other persons and other minds, but rather of the implicit indirect benefit which a recovery of social trust can bring in terms of enhancing an individual's openness to learn from the interpersonal experiences to which they are constantly and inevitably exposed. Since many group members were deprived of secure attachments where they could trust the feedback of their early caregivers, they are able to finally experience a safe base in the group where they can develop trust in the observations made by others. Obviously, this brings with it risks as well as benefits: those whose social environment outside of the group setting requires them to be vigilant and suspicious will benefit little or not at all, and may even deteriorate as a consequence of the increasing trust brought about by group therapy. It is up to the leader of the group to maintain a watchful eye on the individual's circumstances outside of the therapeutic setting and advise and counsel as well as focusing on the primary goal of enhancing interpersonal communication. Despite this risk, group members are able to engage in process that was derailed and begin to develop secure relationships where they can take in the thoughts and feelings of others and begin to consider others' minds as well as their own. Their ability to develop these secure attachments, gain a sense of epistemic trust, and begin to mentalize in the group changes the course of their interpersonal experiences outside of the group.

Bateman, A. W., & Fonagy, P. (2016). *Mentalization-based treatment for personality disorders: A practical guide*. Oxford, UK: Oxford University Press.

Bateman, A. W., & Fonagy, P. (Eds.). (2012). *Handbook of mentalizing in mental health practice*. Washington, DC: American Psychiatric Publishing.

Csibra, G., & Gergely, G. (2006). Social learning and social cognition: The case for pedagogy. In M. H. Johnson & Y. Munakata (Eds.), *Processes of change in brain and cognitive development. Attention and Performance XXI* (pp. 249-274). Oxford, UK: Oxford University Press.

Csibra, G., & Gergely, G. (2009). Natural pedagogy. *Trends in Cognitive Sciences, 13*(4), 148-153. doi: 10.1016/j.tics.2009.01.005

Csibra, G., & Gergely, G. (2011). Natural pedagogy as evolutionary adaptation. *Philosophical Transactions of the Royal Society of London. Series B, Biological Sciences, 366*(1567), 1149-1157. doi: 10.1098/rstb.2010.0319

Fonagy, P., & Allison, E. (2014). The role of mentalizing and epistemic trust in the therapeutic relationship. *Psychotherapy, 51*(3), 372-380. doi: 10.1037/a0036505

Fonagy, P., Gergely, G., Jurist, E., & Target, M. (2002). *Affect regulation, mentalization, and the development of the self*. New York, NY: Other Press.

Fonagy, P., & Luyten, P. (2016). A multilevel perspective on the development of borderline personality disorder. In D. Cicchetti (Ed.), *Development and Psychopathology* (3rd ed.). New York, NY: John Wiley & Sons.

Fonagy, P., Luyten, P., & Allison, E. (2015). Epistemic petrification and the restoration of epistemic trust: A new conceptualization of borderline personality disorder and its psychosocial treatment. *Journal of Personality Disorders, 29*(5), 575-609. doi: 10.1521/pedi.2015.29.5.575